

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26001

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles John Edward Miller

2. Date of Death

Month Day Year
August 15 2000

3. Time of Death

9:04 PM

4a. Facility Name (If not institution, give street and number)

Gilchrist

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

164-07-9202

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 17 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

157 Springside Dr.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant to the Auditor

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Charles Miller

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Singer

19a. Informant's Name/Relationship (Type, Print)

Mrs. Ruth Miller/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

157 Springside Dr. Timonium, Md. 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Nisky Hill Cemetery

Date

8-19-00

20c. Location - City or Town, State

Bethlehem, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

pancreatic cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 16, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W.A. Riley, MD 6701 N. Charles St. Balto. Md 21204

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

State
Registrar8/16/00 9:04 PM Charles
Miller, Charles
Baltimore, Maryland 21215-0020

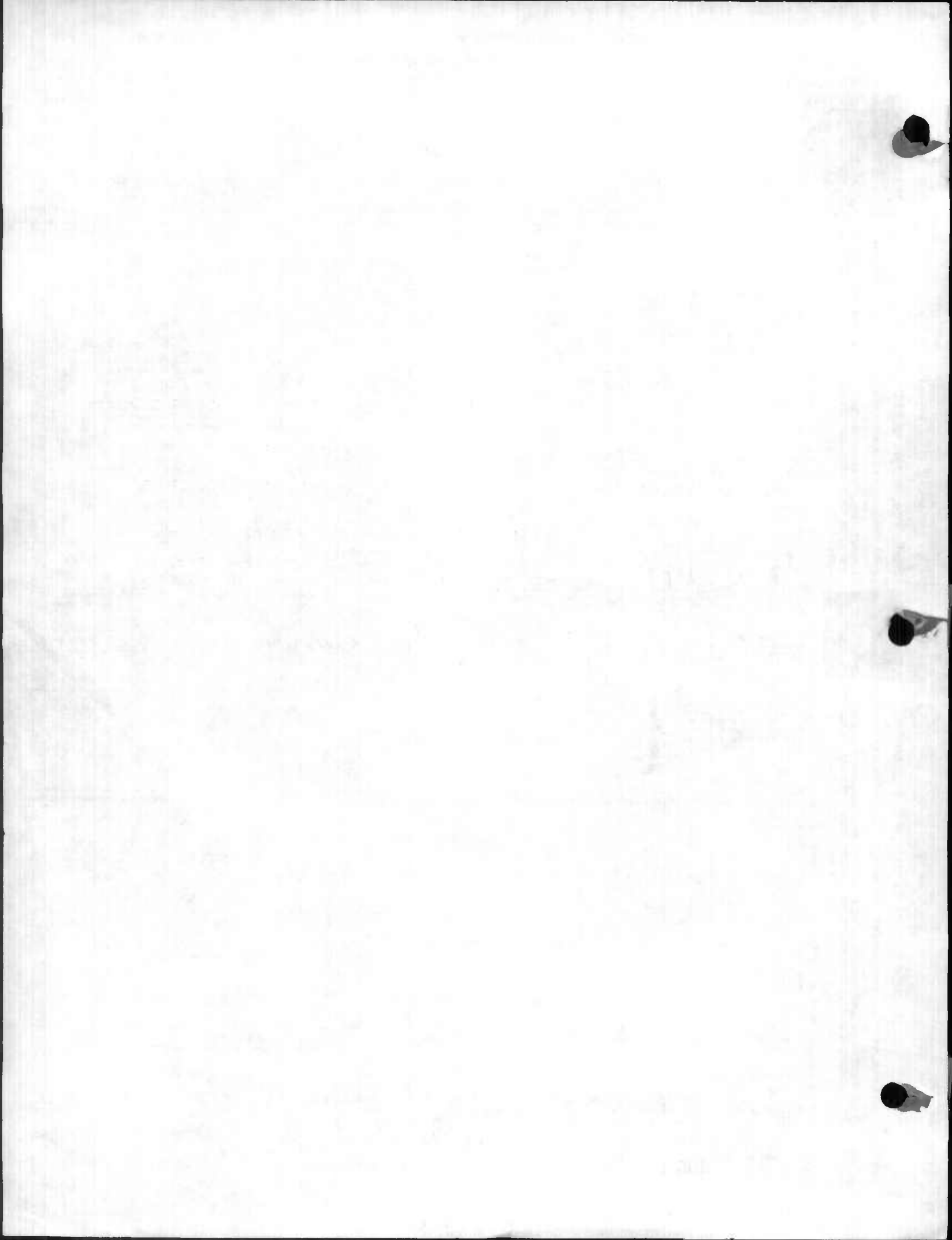
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26002

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Frederick MacKenzie

2. Date of Death

August 15, 2000

Day

3. Time of Death

1:40 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

715 Maiden Choice Ln., #523 Chapel Court

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

082-09-7666

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEP 27, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

715 Maiden Choice Ln., # 523 Chapel Court

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Public High School

17. Father's Name (First, Middle, Last)

Neil Alexander MacKenzie

18. Mother's Name (First, Middle, Maiden Surname)

Emma Huebner

19a. Informant's Name/Relationship (Type, Print)

Dorothy A. MacKenzie / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

715 Maiden Choice Ln., #523 Chapel Ct. Balto., MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 08/16/00

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PROSTATE CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bernard F. Kobzowski, MD

29c. License number

D26473

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard F. Kobzowski, MD 715 MAIDEN CHOICE LANE, BALTIMORE, MD 21228

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26003

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Genevieve Mitchell

2. Date of Death

August

Day

11

Year

2000

3. Time of Death

1:55 am

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

216 24 4001

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 26, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7746 Twin Oaks Road

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

2 years

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Walter Beach

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Hudson

19a. Informant's Name/Relationship (Type, Print)

Melvin Mitchell / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7746 Twin Oaks Road Severn, Maryland 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park 8/14/00

Date

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Dana M. Bromiowski

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

ten days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colon Cancer

Due to (or as a consequence of):

two years

c. possible Sepsis

Due to (or as a consequence of):

ten days

d. Atrial Fibrillation

five years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus type two

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rebecca Gottesman, Resident Physician

29c. License number

21015

29d. Date signed (Month, Day, Year)

August 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Gottesman, 4940 Eastern Avenue, Baltimore, Maryland 21224

State
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26004

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NATALIA MACENKO

2. Date of Death

Month

Day

Year

August 15, 2000

3. Time of Death

3:38 PM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS AT MERCY

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-32-7387

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 18, 1920

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

515 S. MADIERA STREET

10f. Zip Code

21231

10g. Citizen of What Country?

UKRAINE

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

JANITORIAL

17. Father's Name (First, Middle, Last)

WASILIUS LUCYSZYN

18. Mother's Name (First, Middle, Maiden Surname)

ANASTASIA RIZNYK

19a. Informant's Name/Relationship (Type, Print)

ANNA STRYZAK/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6409 EASTERN PARKWAY, BALTIMORE, MARYLAND 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST. MICHAEL'S UKRAINIAN 8/19/00

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME

1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cholangiocarcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

STELLA MARIS AT MERCY

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D40854

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG, 301 ST PAUL PI

BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26005

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNA HEDWICK PETLICKA

2. Date of Death

Month August Day 11 Year 2000

3. Time of Death

12:10 PM

4a. Facility Name (If not institution, give street and number)

BROOKE GROVE REHABILITATION AND NURSING CENTER

4b. City, Town, or Location of Death

SANDY SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

087-18-8471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 8 1907

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Laytonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6401 Manor View Drive

10f. Zip Code

20882

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Minna Quade

19a. Informant's Name/Relationship (Type, Print)

Rev. Dorothy Schmitt - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6401 Manor View Drive Laytonsville, Md 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Union Cemetery

Date

8/14/00

20c. Location - City or Town, State

Burtonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home

7601 Sandy Spring Road Laurel, MD 20707

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. INANITION

Due to (or as a consequence of):

WEEKS

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. VASCULAR DEMENTIA

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

STAFF PHYSICIAN

29c. License number

D42046

29d. Date signed (Month, Day, Year)

August 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROOKE HUFFMAN, MD 1800 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26006

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEON STAIMAN

2. Date of Death

Month Day Year
AUGUST 15 2000 9:35AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN BALTIMORE

4c. County of Death

5. Social Security Number

078-26-4413

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 10, 1929

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

3 KESTREL LANE

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRODUCTION

16b. Kind of Business/Industry

MANUFACTURER

17. Father's Name (First, Middle, Last)

ISAAC

STAIMAN

18. Mother's Name (First, Middle, Maiden Surname)

RUTH

HALPERN

19a. Informant's Name/Relationship (Type, Print)

GERALDINE STAIMAN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 KESTREL LANE, PIKESVILLE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

8/16/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LOUDON PARK FUNERAL HOME

3620 WILKENS AVE., BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. RAO, M.D.
NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Benjamin G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 26007

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) RICHARD ALLEN SPITZER				2. Date of Death Month Day Year AUGUST 10, 2000		3. Time of Death 11:49am	
4a. Facility Name (If not Institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
5. Social Security Number 226-46-5328		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 1, 1937	
9. Birthplace (State or Foreign Country) VIRGINIA							
Usual Residence of Decedent							
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 X Yes 2 No	
10e. Street and Number 3607 FAIRHAVEN AVE.				10f. Zip Code 21226		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1966		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry FRIEGHT COMPANY	
17. Father's Name (First, Middle, Last) CHARLES WESLEY SPITZER				18. Mother's Name (First, Middle, Maiden Surname) HAZEL V. BREEDEN			
19a. Informant's Name/Relationship (Type, Print) SHIRLEY K. SPITZER (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3607 FAIRHAVEN AVE., BALTIMORE, MD 21226			
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Data 8/14/00		20c. Location - City or Town, State BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility LOUDON PARK FUNERAL HOME 3620 WILKINS AVE., BALTIMORE, MD 21226			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. ARRHYTHMIAS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 DAY 1 HR.			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE CONGESTIVE HEART FAILURE						23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown	
24a. Was an autopsy performed? 1 X Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No					
25. Was case referred to medical examiner? 1 X Yes 2 No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 X Natural 2 Accident 3 Suicida 4 Homicida 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 X Yes 2 No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  FIRST YEAR RESIDENT		29c. License number P13470		29d. Date signed (Month, Day, Year) AUGUST 16, 2000			
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) MOHAMMED ALATTAR, 3001 SOUTH HANOVER ST., BALTIMORE, MD. 21225							
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RECEIVED
FEBRUARY 1942

RECEIVED
FEBRUARY 1942

RECEIVED
FEBRUARY 1942

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPHYG786 8/17/2000 EW

Certificate of Death

Reg. No.

00 26008

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Margaret Swift</i>				2. Date of Death Month <i>August</i> Day <i>12</i> Year <i>2000</i>		3. Time of Death <i>1:12 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>218-18-0203</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>75</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov. 25, 1924</i>		
	10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore City</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>Louis Dubiel</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Magdalene Ludwig</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Theresa Purser / Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1419 Knox Valley Drive, Brentwood TN 37027</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holy Cross Cemetery</i>		20c. Location - City or Town, State <i>Baltimore Maryland</i>			
21. Signature of Funeral Service Licensee <i>Victor P. Doda, Jr.</i>				22. Name and Address of Facility <i>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Basal ganglia hemorrhage</i> Due to (or as a consequence of): <i>b. HYPERTENSION</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>P12446</i>		29d. Date signed (Month, Day, Year) <i>August 12, 2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>T Mattingly MD 22 South Green St Baltimore, MD 21201</i>									
31. Date filed (Month, Day, Year) <i>AUG 17 2000</i>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26009

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret A. Savarese				2. Date of Death Month Day Year Aug. 14, 2000				3. Time of Death 3:05 p.m.		
	4a. Facility Name (If not institution, give street and number) 11107 Willow Bottom Drive				4b. City, Town, or Location of Death Columbia				4c. County of Death Howard		
Funeral Director	5. Social Security Number 305-50-9338		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) April 9 1947		9. Birthplace (State or Foreign Country) Indiana		
	Usual Residence of Decedent										
10a. State MD		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 11107 Willow Bottom Drive				10f. Zip Code 21044				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary School Teacher				16b. Kind of Business/Industry Education			
17. Father's Name (First, Middle, Last) John Robert Whitehead				18. Mother's Name (First, Middle, Maiden Surname) Margaret Hyland							
19a. Informant's Name/Relationship (Type, Print) Pinchos L. Andreen				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1113 Columbia, MD 21044							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Memorial Park			20c. Location - City or Town, State Columbia, Maryland		20d. Date 8/17/00			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045							
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Cancer stage IV Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast cancer stage II, Anemia, Bronchial obstruction								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		26a. Date of Injury (Month, Day Year)		26b. Time of Injury M		26c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26d. Describe how injury occurred			
27a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28b. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Signature and title of certifier 				29c. License number D30573				29d. Date signed (Month, Day, Year) 8-15-00			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Jon Mrs. Fnd. MD 11065 White Patent Parkway Columbia MD 21041											
31. Date filed (Month, Day, Year) AUG 17 2000				32. Registrar's Signature 							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26010

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Rose Marie Sica						2. Date of Death Month August Day 13 Year 2000		3. Time of Death 10:35 AM	
4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
5. Social Security Number 215-10-3090		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 22, 1917		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1619 Four Georges Court				10f. Zip Code 21222		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Vincent Liberto					18. Mother's Name (First, Middle, Maiden Surname) Lucia Cassio				
19a. Informant's Name/Relationship (Type, Print) Frank J. Sica/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Lynx Court, Bel Air, Maryland 21014					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Cr.		Date 8/17/00		20c. Location - City or Town, State Laurel, Maryland			
21. Signature of Funeral Service Licensee Thomas L. Lemmer MO0741				22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Tariq		29c. License number D43725-		29d. Date signed (Month, Day, Year) August 13, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tariq Mahmood 2300 Dulaney Valley Road, Timonium, Maryland 21093									
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature Tariq Mahmood							

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26011

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Therese M SPEARS		2. Date of Death Month 8 Day 12 Year 00		3. Time of Death 1356
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital		4b. City, Town, or Location of Death Columbia		4c. County of Death Howard
Funeral Director	5. Social Security Number 213-02-0369	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 16, 1965		9. Birthplace (State or Foreign Country) Louisiana		
To Be Completed by Funeral Director	10a. State MD		10b. County Howard		10c. City, Town or Location Columbia
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10a. Street and Number 6298 Leafyscreen		10f. Zip Code 21045		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Assistant		16b. Kind of Business/Industry Wholesale
	17. Father's Name (First, Middle, Last) Floyd R. Spears		18. Mother's Name (First, Middle, Maiden Surname) Faylice Henry		
	19a. Informant's Name/Relationship (Type, Print) Faylice H. Spears/Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6298 Leafyscreen, Columbia, Maryland 21045		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Memorial Park		Date 8/17/00
	20c. Location - City or Town, State Clarksville, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045			
Physician /Medical Examiner	23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Insulin Dependent Diabetes Mellitus Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Seizure Disorder				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier Marshall Freedman, D.O.		29c. License number H37211		29d. Date signed (Month, Day, Year) Aug. 13, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshall Freedman, 2 Knoll N., Columbia, MD 21045				
State Registrar	31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature 		

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 26012

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDITH W. SCHULTZE				2. Date of Death Month Day Year AUGUST 14, 2000		3. Time of Death 2:30 PM	
	4a. Facility Name (If not institution, give street and number) PERRING PARKWAY GENESIS ELDERCARE				4b. City, Town, or Location of Death PARKVILLE		4c. County of Death BALTIMORE COUNTY	
Funeral Director	5. Social Security Number 215-09-2668		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) JANUARY 20, 1908	
	Usual Residence of Decedent		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1327 GLENDALE ROAD		10f. Zip Code 21239		10g. Citizen of What Country? UNITED STATES OF AMERICA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (14 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE SECRETARY		16b. Kind of Business/Industry RETAIL OFFICE				
17. Father's Name (First, Middle, Last) JOSEPH WUSTLAND				18. Mother's Name (First, Middle, Maiden Surname) URITH HARGEST				
19a. Informant's Name/Relationship (Type, Print) FRANCES BROCATO				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9926 FERNDALE AVENUE / COLUMBIA, MARYLAND 21046				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		Date AUG 17, 2000		20c. Location - City or Town, State BALTIMORE, MARYLAND		
21. Signature of Funeral Service Licensee Donald R. Watson, Jr. #M00612				22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTIMORE, MD. 21214				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic obstructive lung disease								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Michael J. ...				29c. License number D08358		29d. Date signed (Month, Day, Year) Aug 16 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACIE V. PATRICIO R.T.P. 18903 HARFORD ROAD BALT. MD 21234								
31. Date filed (Month, Day, Year) AUG 17 2000				32. Registrar's Signature B. ...				

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State of Maryland / Department of Health and Mental Hygiene 00 26013

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vera B. Sala				2. Date of Death Month Day Year August 16 2000		3. Time of Death 5:55 A.M.		
	4e. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 220-30-7203		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 13, 1935		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Baltimore		10c. City, Town or Location Rosedale		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2005 Wintergreen Place		10f. Zip Code 21237		
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clothing cutter				16b. Kind of Business/Industry Clothing				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Hugh L. Boyle				18. Mother's Name (First, Middle, Maiden Surname) Margaret				
	19a. Informant's Name/Relationship (Type, Print) Glenn Williams-son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4624 Forge Acres Dr., Perry Hall, MD 21128				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Mem'l Park		20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee William G. Dau				22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 15 MINUTES	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) M		28b. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28c. Describe how injury occurred				28d. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier David B. Peichert	
	29c. License number D31008				29d. Date signed (Month, Day, Year) 8-16-00				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID PEICHERT, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237							31. Date filed (Month, Day, Year) AUG 17 2000	
	32. Registrar's Signature S. Sparks							33. State Registrar AUG 17 2000	

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26014

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janet Virginia Schmidtman				2. Date of Death Month Day Year AUGUST 11, 2000		3. Time of Death 1906 PM			
	4a. Facility Name (If not institution, give street and number) 525 W. 27TH STREET				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A			
Funeral Director	5. Social Security Number 219-42-9396		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) JAN 7, 1939			
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 525 W. 27th Street 1st Floor				10f. Zip Code 21211	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic				17. Father's Name (First, Middle, Last) Frank Louis Schmidtman	
	18. Mother's Name (First, Middle, Maiden Surname) Augusta Elma Maynard				19a. Informant's Name/Relationship (Type, Print) Frank Edward Schmidtman/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Bayner Road Essex, MD 21221	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.				20c. Location - City or Town, State 8-14-00 Baltimore, MD	
	21. Signature of Funeral Service Licensee Dawn McDonald				22. Name and Address of Facility Cremation Society of MD, Inc.				22. Name and Address of Facility 299 Frederick Road Baltimore, MD 21228	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? partial 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Dennis J. Chute				29c. License number OCME		29d. Date signed (Month, Day, Year) AUGUST 12, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201									
	31. Date filed (Month, Day, Year) AUG 17 2000				32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0055.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26015

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Clara</u>		2. Date of Death Month <u>August</u> Day <u>16</u> Year <u>2000</u>		3. Time of Death <u>08:26</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>220-30-4950</u>	6. Sex <u>1</u> <input type="checkbox"/> M <u>2</u> <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>64</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>1</u> <u>24</u> <u>36</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <u>2228 E. Chase Street</u>		10f. Zip Code <u>21213</u>		10g. Citizen of What Country? <u>USA</u>
	11. Marital Status <u>1</u> <input checked="" type="checkbox"/> Never Married <u>2</u> <input type="checkbox"/> Married <u>3</u> <input type="checkbox"/> Widowed <u>4</u> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>
	15. Decedent's Education (Specify only highest grade completed) <u>16th</u> Elementary/Secondary (0-12) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Bar Maid</u>		16b. Kind of Business/Industry <u>Thunderbird Lounge</u>
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Willie Smith</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Florence Williams</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>Maryanne Smith - Daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2228 E. Chase St. Baltimore, Maryland 21213</u>		
	20a. Method of Disposition <u>1</u> <input checked="" type="checkbox"/> Burial <u>2</u> <input type="checkbox"/> Cremation <u>3</u> <input type="checkbox"/> Removal from State <u>4</u> <input type="checkbox"/> Donation <u>5</u> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Voshell Cemetery</u>		
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Milker's Metropolitan Chapel, P.C.</u> <u>1639 N. Broadway Balto. Md. 21213</u>		
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death)		a. <u>Brain Herniation</u> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <u>15 hours</u>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <u>Subdural hematoma</u> Due to (or as a consequence of):		<u>48 hours</u>
	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	<u>Renal Failure, uremia</u>				
	<u>Status post ruptured Thoracic aorta aneurysm</u>				
	23b. Did tobacco use contribute to the cause of death? <u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No <u>3</u> <input type="checkbox"/> Probably <u>4</u> <input checked="" type="checkbox"/> Unknown				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <u>1</u> <input checked="" type="checkbox"/> Inpatient <u>2</u> <input type="checkbox"/> ER/Outpatient <u>3</u> <input type="checkbox"/> DOA Other: <u>4</u> <input type="checkbox"/> Nursing Home <u>5</u> <input type="checkbox"/> Residence <u>8</u> <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <u>1</u> <input checked="" type="checkbox"/> Natural <u>5</u> <input type="checkbox"/> Pending investigation <u>2</u> <input type="checkbox"/> Accident <u>6</u> <input type="checkbox"/> Could not be determined <u>3</u> <input type="checkbox"/> Suicide <u>4</u> <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>
	28c. Injury at Work? <u>1</u> <input type="checkbox"/> Yes <u>2</u> <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29e. Certifier (Check only one) <u>1</u> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <u>[Signature] MD</u>		29c. License number <u>RES-001</u>		29d. Date signed (Month, Day, Year) <u>August 16 2000</u>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Kelly L Grogan 606 North Walker Street Baltimore MD 21207-9106</u>				
	31. Date filed (Month, Day, Year) <u>AUG 17 2000</u>		32. Registrar's Signature <u>[Signature]</u>		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 28 A_F 7/86 8-30-00 WR.

Certificate of Death

Reg. No.

00 26016

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Joseph Scanlon		2. Date of Death Month Day Year August 13 2000		3. Time of Death 12:17 P.M.
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital		4b. City, Town, or Location of Death Glen Bernie		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 213 98 0103	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 28, 1980		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 16 Fourth Avenue S.W.		10f. Zip Code 21061		10g. Citizen of What Country? U.S.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
	17. Father's Name (First, Middle, Last) Joseph L. Scanlon		18. Mother's Name (First, Middle, Maiden Surname) Lilia I. Burns		
	19a. Informant's Name/Relationship (Type, Print) Lilia Tharp / Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Fourth Avenue S.W. Glen Burnie, Maryland 21061		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 8/17/00 Baltimore, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METHANDONE INTOXICATION				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8-13-00		28b. Time of Injury UNKNOWN
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 4TH AVE. SW, GLEN BURNIE, MD		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 15, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Lohr, M.D. 111 Penn Street, Baltimore, Maryland 21201				
	State Registrar	31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26017

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Naomi Smith</u>				2. Date of Death Month <u>August</u> Day <u>15</u> Year <u>2000</u>				3. Time of Death <u>07:57 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Shock Trauma Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>217 09 0325</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>80</u> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <u>August 30, 1919</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Baltimore</u>	
Usual Residence of Decedent										
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
10a. Street and Number <u>419 Bon Air Road</u>										
10f. Zip Code <u>21225</u>										
10g. Citizen of What Country? <u>U.S.</u>										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th</u> College (1-4or 5+) <u>Scout</u>										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Scout</u>										
16b. Kind of Business/Industry <u>Social Security Adm.</u>										
17. Father's Name (First, Middle, Last) <u>John Doffmyer</u>										
18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Peacher</u>										
19a. Informant's Name/Relationship (Type, Print) <u>Ruth Ingrassia / Daughter</u>										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>224 Poplar Avenue Glen Burnie, Maryland 21061</u>										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Glen Haven Memorial Park</u>										
20c. Location - City or Town, State <u>8/19/00 Glen Burnie, Maryland</u>										
21. Signature of Funeral Service Licensee <u>Dan M. Zimowski</u>										
22. Name and Address of Facility <u>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</u>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Respiratory Failure</u> Due to (or as a consequence of): <u>b. Fractured ribs</u> Due to (or as a consequence of): <u>c. Motor Vehicle Crash</u> Due to (or as a consequence of): d. <u>atipb Nocty</u>										
Approximate Interval Between Onset and Death										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Obstructive Pulmonary Disease</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year) <u>July 30 2000</u>										
28b. Time of Injury <u>4:00 PM</u>										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred <u>Motor Vehicle Crash</u>										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Street</u>										
28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>Rt. 170 - Anne Arundel Co.</u>										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <u>Kerry Kole DO</u>										
29c. License number <u>H55103</u>										
29d. Date signed (Month, Day, Year) <u>August 15 2000</u>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Kerry Kole 22 S Greene St. Baltimore MD</u>										
31. Date filed (Month, Day, Year) <u>AUG 17 2000</u>										
32. Registrar's Signature <u>[Signature]</u>										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26018

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Frank Sadler, Sr.				2. Date of Death Month Day Year August 11 2000		3. Time of Death 7:35 pm		
	4a. Facility Name (If not institution, give street and number) St Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death -----		
Funeral Director	5. Social Security Number 213-34-4990		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 23, 1936		
	9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent									
10a. State Maryland		10b. County -----		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3527 Old Frederick Road				10f. Zip Code 21229		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Mechanic			16b. Kind of Business/Industry Glass Company		
17. Father's Name (First, Middle, Last) John Sadler				18. Mother's Name (First, Middle, Maiden Surname) Mollie A. Schalitzsky					
19a. Informant's Name/Relationship (Type, Print) Mrs. Elaine R. Sadler (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 Old Frederick Road Baltimore, Md 21229					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 8/15		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Robert J. Sadler, Jr.				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, Md 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Progressive Pancreatic Cancer Due to (or as a consequence of): Gram Negative Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death 14 months 1 week	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier MD				29c. License number P-13596			29d. Date signed (Month, Day, Year) August 11 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olafipo Adeniyi, MD St Agnes Hospital									
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature G Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26019

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD TAVENNER

2. Date of Death

Month Day Year
AUGUST 15 2000

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-07-1650

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 20, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5510 Old Frederick Road

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
3

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pressman

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

unobtainable

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Twamley

19a. Informant's Name/Relationship (Type, Print)

Anthony Evans-Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5510 Old Frederick Road, Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

8-16-00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Lisa S. Jefferson

22. Name and Address of Facility

Loudon Park Funeral Home

3620 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. CHRONIC OBSTRUCTIVE PULMONARY
DISEASE
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:2 ☐ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

K. S. Rao M.D.

29c. License number

043462

29d. Date signed (Month, Day, Year)

AUGUST 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. S. Rao M.D.
NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26020

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Trainor

2. Date of Death

AUGUST 14, 2000

3. Time of Death

8:10 pm

4a. Facility Name (If not institution, give street and number)

3201 FLEET STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

231-42-5963

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 24, 1936

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3201 FLEET STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ASSEMBLY LINE

16b. Kind of Business/Industry

MARYLAND CUP

17. Father's Name (First, Middle, Last)

THOMAS H. CREASEMAN

18. Mother's Name (First, Middle, Maiden Surname)

BONNIE EDGE

19a. Informant's Name/Relationship (Type, Print)

JAMES W. TRAINOR/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3201 FLEET ST. APT. A, BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREENMOUNT CEMETERY 8/16/00 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease 5 years

Due to (or as a consequence of):

b. Hypothyroidism 2 years

Due to (or as a consequence of):

c. Cirrhosis 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

29c. License number

DZ4334

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Geriatric Center 5505 Hopkins Bayview Circle

State
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26021

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eloise W. Wilson

2. Date of Death

Month

Day

Year

AUGUST 16 2000 12:30 PM.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-22-7413

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT 12, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14 Sanford Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

John H. White

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Reed

19a. Informant's Name/Relationship (Type, Print)

Louis J. Weinkam, Sr./attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1002 Frederick Road Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 08/17/00

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

20 YEARS

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

MEDICAL RESIDENT

29c. License number

P12588

29d. Date signed (Month, Day, Year)

AUG. 16 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BO THAPRU MICHAEL, MD

ST. AGNES HOSPITAL
900 CATON AVENUE, MD 21215.

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNAME WILSON ELOISE
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26022

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Arden Willaman				2. Date of Death Month Day Year AUG 13, 2000		3. Time of Death 6:43pm	
	4a. Facility Name (If not institution, give street and number) Gilchrist Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 278-30-6187		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 19, 1935	
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 812 Drohomor Place		10f. Zip Code 21210		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1958-1961		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cellist		16b. Kind of Business/Industry Orchestra				
17. Father's Name (First, Middle, Last) Kenneth Willaman				18. Mother's Name (First, Middle, Maiden Surname) Helen Burdine Rabel				
19a. Informant's Name/Relationship (Type, Print) Stephen W. Fisher/companion				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 Drohomor Place Baltimore, MD 21210				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Date 8/14/00		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Dawn F. McDonald				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. pancreatic cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier A. Anthony Riley, MD				29c. License number D25205		29d. Date signed (Month, Day, Year) August 14, 2000		
30. Name and address of person who completed cause of death item 23a (Type, Print) Mr. A. Riley, 6701 N. Charles St. Balto. MD 21204								
31. Date filed (Month, Day, Year) AUG 17 2000				32. Registrar's Signature [Signature]				

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26023

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Frances Wilt

2. Date of Death

August 15 2000

3. Time of Death

1725

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

230-24-9092

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 21, 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1404 Terry Way

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Real Estate Agent

16b. Kind of Business/Industry

Self-Employed
Real Estate

17. Father's Name (First, Middle, Last)

Hollie B. Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Zella Abshire

19a. Informant's Name/Relationship (Type, Print)

Janet L. Keathley (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3408 Gem Drive, Pueblo, Colorado 81005

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem'l Gar

Date

8/19/00

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Amanda Kelly

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Sepsis
PeritonitisApproximate
Interval Between
Onset and Death3 days
1 weekSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

Circulosis.

6 months

c.

Due to (or as a consequence of):

Autoimmune Liver Disease

1 year.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida
4 ☐ Homicida28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Peter L. Drost, MD

29c. License number

H39022

29d. Date signed (Month, Day, Year)

August 16 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER L. DROST, MD 1308 BUSINESS CENTER WAY EAGERWOOD MD

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Beverly Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26024

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FERRELL WILLIAMS				2. Date of Death Month AUGUST Day 14 Year 2000		3. Time of Death 0914 AM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 249-32-1635		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) AUGUST 22, 1926	
	9. Birthplace (State or Foreign Country) SOUTH CAROLINA		10a. State md		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4221 Belvue Ave		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER		16b. Kind of Business/Industry Bethlehem Steel Corp			
	17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) unknown		19a. Informant's Name/Relationship (Type, Print) Harry Cokley - Son			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4221 Belvue Ave Balto md. 21215		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus mem. Park		20c. Location - City or Town, State Arbutus, md.	
	21. Signature of Funeral Service Licensee Lewis T. Gwynn		22. Name and Address of Facility Lewis T. Gwynn Funeral Home		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Renal Failure Due to (or as a consequence of): Rhabdomyolysis Due to (or as a consequence of): Ischemic right leg Due to (or as a consequence of): Severe atherosclerosis with occlusion of right iliac artery			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier V. Dixon King, Jr.		29c. License number 043453		29d. Date signed (Month, Day, Year) AUGUST 16, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. DIXON KING, JR., MD 5401 OLD COURT RD RANDALLSTOWN, MARYLAND		31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED 122101:ITEMS#23a,b,25&ptII per ME G802 SS

Certificate of Death

Reg. No.

00 26025

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brenda Carol Willhide				2. Date of Death Month August Day 10 Year 2000		3. Time of Death 6:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 5205 Brookwood Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 214 52 9734		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 30, 1948	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 5205 Brookwood Road		10f. Zip Code 21225	
	10g. Citizen of What Country? U.S.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Allen Grubb				18. Mother's Name (First, Middle, Maiden Surname) Thelma Hoffman			
	19a. Informant's Name/Relationship (Type, Print) Daniel Willhide / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5205 Brookwood Road Baltimore, Maryland 21225			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 8/14/00 Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Sharon H. [Signature]				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC ARRHYTHMIA Cardio PULMONARY ARREST DEHYDRATION						Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FIBROMYALGIA						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) -		28b. Time of Injury - M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred -		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) -		28f. Location (Street and Number or Rural Route Number, City or Town, State) -		28g. Location (Street and Number or Rural Route Number, City or Town, State) -	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.						29b. Signature and title of certifier Dr. Manejwala	
	29c. License number JD9748						29d. Date signed (Month, Day, Year) 8/13/00	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALIE MANEJWALA, MD.						31. Date filed (Month, Day, Year) AUG 17 2000	
	32. Registrar's Signature [Signature]						33. Registrar's Signature [Signature]	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26026

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy J. Wells

2. Date of Death
Month Day Year

August 13 2000

3. Time of Death

2:10 AM

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-40-5282

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02 13 1907

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

40 Hamill Court

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Balto. City Schools

17. Father's Name (First, Middle, Last)

John Severn Wells

18. Mother's Name (First, Middle, Maiden Surname)

Martha Elizabeth Henzler

19a. Informant's Name/Relationship (Type, Print)

James Ryan/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Rumford Drive, Suite 202 Catonsville, Md 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park

Date

08 16

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home, Inc

736 Edmonson Avenue, Balto., Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Recurrent pneumonia

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide 6 ☐ Could not be determined4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bernard F. Kobayashi, MD

29c. License number

711 MAIDEN D26473

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bernard F. Kobayashi, MD 711 MAIDEN CHURCH LANE BALTO MD 21228

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Bernard F. Kobayashi

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26027

AUGUST 13, 2000 3:25 PM
 Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
 JOHN WITTMAYER
 Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.
 5x
 7/17

To Be Completed by Funeral Director

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John W. Wittmyer				2. Date of Death Month Day Year 08 13 2000				3. Time of Death 3:25p.m.	
	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-14-5849	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 07 06 1916		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent									
10a. State Md		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 221 Osborne Avenue				10f. Zip Code 21228		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator			16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) John Wittmyer				18. Mother's Name (First, Middle, Maiden Surname) May Daniels						
19a. Informant's Name/Relationship (Type, Print) Jean Wittmyer/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Osborne Avenue, Catonsville, Md 21228						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date 08 17		20c. Location - City or Town, State Baltimore, Md.				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228						

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Pancreatic cancer</u> Due to (or as a consequence of): b. <u>Liver cancer</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 7/21/00 7/21/00	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ascites</u> <u>NIDDM.</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u>HOSPICE</u>			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D35712		29d. Date signed (Month, Day, Year) 8/14/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Richey Hospice #28 Eutaw St. 21201 MD.					
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature 			

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26028

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Herbert L. Wright

2. Date of Death

Month Day Year
August 15, 2000

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

225-05-0931

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 1, 1912

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5225 Pooks Hill Road # 1104 N

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPPLY CLERK

16b. Kind of Business/Industry

U.S. GOVT

17. Father's Name (First, Middle, Last)

Herbert Wright

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Watkins

19a. Informant's Name/Relationship (Type, Print)

Beatrice C. Wright

WIFE

19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)

5225 Pooks Hill Road Bethesda, Maryland 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery

Date

8/21/00

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Robert B Baker Jr.

22. Name and Address of Facility

CHINN FUNERAL SERVICE
2605 So. Shillington Rd. ARL, Va. 22206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attan KASID M.D., Ph.D.

29c. License number

D 55054

29d. Date signed (Month, Day, Year)

AUGUST 15, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ATTAN KASID 17519 REDLAND AV., ROCKVILLE, MD 20855

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

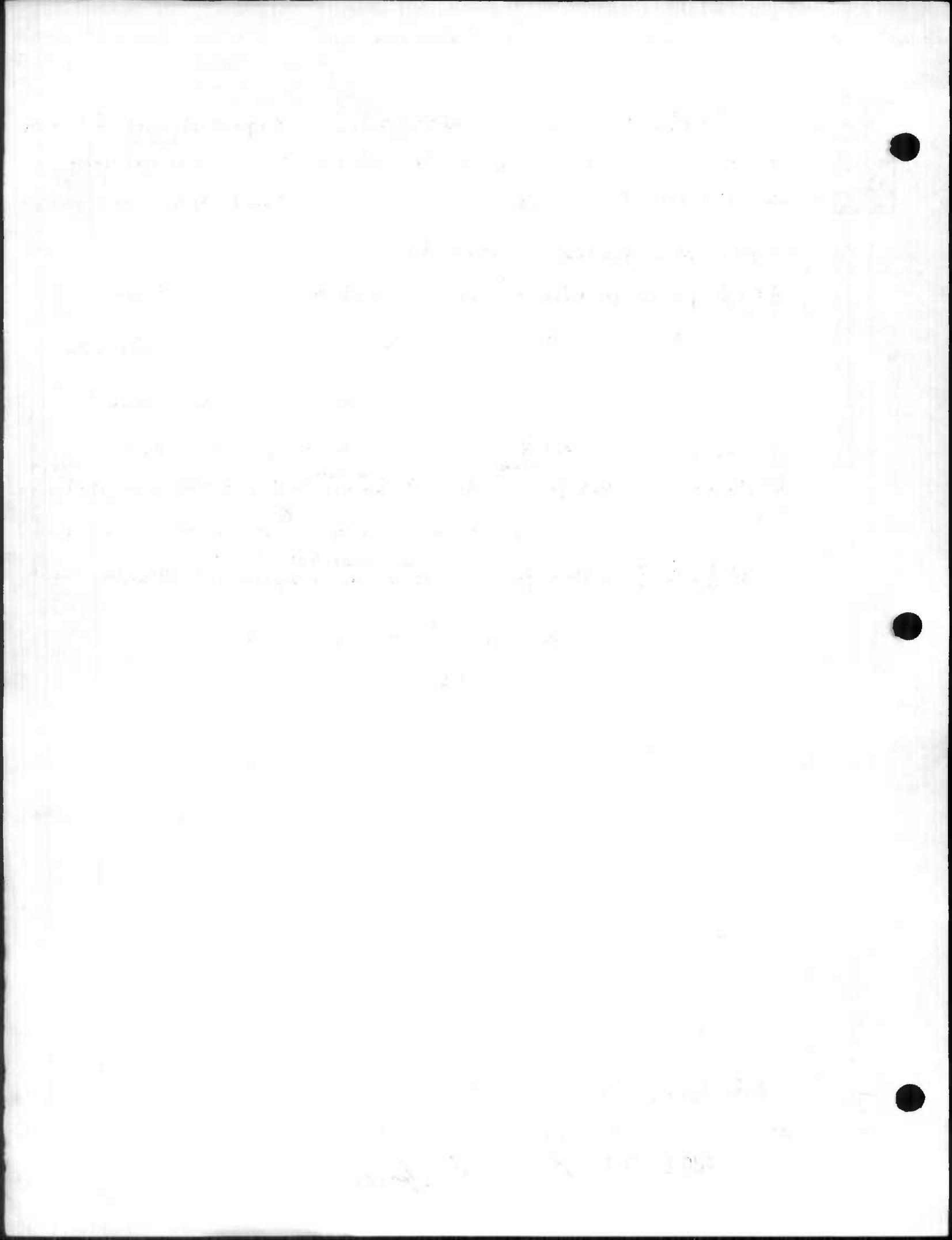
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26029

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SALLIE ATKINS				2. Date of Death Month Day Year July 31 2000		3. Time of Death 5:26p.m.	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579 26 2156	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 18, 1925		9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Seat Pleasant		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 7223 Hylton Street				10f. Zip Code 20743		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse		16b. Kind of Business/Industry D.C. General Hospital		
17. Father's Name (First, Middle, Last) James Brown				18. Mother's Name (First, Middle, Maiden Surname) Genie Heard				
19a. Informant's Name/Relationship (Type, Print) Herbert Atkins/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7223 Hylton Street Seat Pleasant, MD 20743				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Cem.		Data 8-3-00		20c. Location - City or Town, State Laurel, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Atherosclerotic Heart Disease Due to (or as a consequence of): b. Morbid Obesity Due to (or as a consequence of): c. Hyperlipidemia Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Embolism Alzheimers Disease								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D16721		29d. Date signed (Month, Day, Year) August 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vernon C. Smith, M.D. 5223 Georgia Avenue NW Washington DC								
31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Aug 2 500

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26030

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID LEROY BRAWNER

2. Date of Death

Month Day Year
August 4, 2000

3. Time of Death

11:47PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

215-70-7759

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

42

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 3, 1957

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

110784 OAK MANOR DRIVE

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1X Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

GUN MAKER

16b. Kind of Business/Industry

GUN MANUFACTURER

17. Father's Name (First, Middle, Last)

FRANCIS LEROY BRAWNER

18. Mother's Name (First, Middle, Maiden Surname)

MARY ESTELLE WARE BRAWNER

19a. Informant's Name/Relationship (Type, Print)

MARY E. BRAWNER / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110784 OAK MANOR DRIVE, WALDORF, MARYLAND 20601

20a. Method of Disposition

1X Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ST. JOSEPH'S CHURCH CEM.

Date

8/9/00

20c. Location - City or Town, State

POMFRET, MARYLAND

21. Signature of Funeral Service Licensee

Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sudden Cardiac Death

Approximate
Interval Between
Onset and Death

< 40 Minutes

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
Ventricular Tachycardia

< 40 Minutes

c. Due to (or as a consequence of):
Cor pulmonale

years

d. Due to (or as a consequence of):
Severe Sarcoidosis

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tracheobronchitis

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Synbul Chon M.D.

29c. License number

D37174

29d. Date signed (Month, Day, Year)

8/5/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Song C. Chon, M.D. 7C Post Office Rd, Waldorf, Maryland 20602

State
Registrar

31. Date filed (Month, Day, Year)

AUG 08 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

00031 00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 6 per fh G787 9/8/00 yf State of Maryland / Department of Health and Mental Hygiene

Amend# 23a Part 1 & II. Per PHYS. PGC 8-4-2000 Certificate of Death

Reg. No.

00 26031

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAYO E BANKS

2. Date of Death

Month JULY Day 29 Year 2000

3. Time of Death

1:35 PM

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

223-96-0981

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 03-28-57

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

6334 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

Willie BANKS

18. Mother's Name (First, Middle, Maiden Surname)

Louise B. BANKS

19a. Informant's Name/Relationship (Type, Print)

HAZEL BROWN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3100 WARDEN ST. N.W. Washington, D.C. 20010

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

8/2/00

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

James E. Williams

22. Name and Address of Facility

The House of Williams Funeral Service Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

PNEUMONIA ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

36 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

ASPIRATION

5 Days

40 hours

c. Due to (or as a consequence of):

2-5 days

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

RECURRENT ASPIRATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James E. Williams

29c. License number

D 36974

29d. Date signed (Month, Day, Year)

JULY 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID O. NYANJAN MD 10724 LITTLE PATUXENT PARKWAY

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

James E. Williams

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26032

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY Bumbry

2. Date of Death

Month
07Day
30Year
2000

3. Time of Death

13:25p

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-46-8704

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

13-June-1933

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5654 Rock Quarry Terrace

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Docket Clerk

16b. Kind of Business/Industry

US Patent Department

17. Father's Name (First, Middle, Last)

Jack Brown

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Shorts

19a. Informant's Name/Relationship (Type, Print)

Elijah Bumbry/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5654 Rock Quarry Terrace Forestville, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

8/5/2000

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Lanerne Montgomery

22. Name and Address of Facility

Tyrone J. Young Funeral Services

719 Kennedy St., NW Wash., DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiac arrhythmias

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPTIC KNEE

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh A. Bhatnagar

29c. License number

D46478

29d. Date signed (Month, Day, Year)

7-31-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh A. Bhatnagar 7501 Sunnyside Rd #1307 Clinton MD 20735

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

Suresh A. Bhatnagar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, located at the top center of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26033

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anastasius K. Beasley				2. Date of Death Month Day Year July 27, 2000		3. Time of Death 8:15am	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 457-40-3944	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 15, 1928		9. Birthplace (State or Foreign Country) Leesburg, Va.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Clinton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 9102 Matador Ct.				10f. Zip Code 20735		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dispatcher				16b. Kind of Business/Industry D. C. Public Schools	
	17. Father's Name (First, Middle, Last) John William Gaskins				18. Mother's Name (First, Middle, Maiden Surname) Bertha Carr Hall			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Michael Green / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9102 Matador Ct. Clinton, Md. 20735			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Data 8/2/00		20c. Location - City or Town, State Arlington, Va.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADULT RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RHEUMATOID ARTHRITIS HYPERTENSION DIABETES MELLITUS							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D53885		29d. Date signed (Month, Day, Year) 7/28/2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENKAT. S. RAMANATHAN 7501 SURRATTS ROAD #307 CLINTON MD 20735							
	31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature 					

ORIGINAL

00 1 5000

0005 1 9 300

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26034

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SUSIE M. BENEFIELD

2. Date of Death

Month Day Year
JULY 27 2000

3. Time of Death

05:11 A.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

709-10-4839

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1909

9. Birthplace (State or Foreign Country)

Albany, GA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8110 Phelps Place

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Domestic Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Harry Marshall

18. Mother's Name (First, Middle, Maiden Surname)

Della K. Isom

19a. Informant's Name/Relationship (Type, Print)

Carolyn Mitchell - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8110 Phelps Place, Forestville, Maryland 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Lawn Cemetery

Date

8/5/2000

20c. Location - City or Town, State

Broward Co., Fla.

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home, Inc.

4001 Benning Road, N. E., Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DYSRHYTHMIA

Due to (or as a consequence of):

b. POSSIBLE PULMONARY EMBOLUS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 MIN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETIS MELLITUS

RECENT LAPARASIGM CHOLYCYSTECTORY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mary F. Hart

29c. License number

C1 0004095 DE

29d. Date signed (Month, Day, Year)

JULY 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY F. HART, MAJ, USAF, MD

89 MDG/1050 W. PERIMETER RD.

ANDREWS AIR FORCE BASE, MD 20762-6600

State
Registrar

31. Date filed (Month, Day, Year)

JUL 31 2000

32. Registrar's Signature

Beverly B. Sparks

NAME: SUSIE BENEFIELD
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26035

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Justelma Martin Briggs				2. Date of Death Month Day Year 07/27/2000				3. Time of Death 7:25 pm		
	4a. Facility Name (If not institution, give street and number) 1524 Jutewood Ave., Landover, MD 20785				4b. City, Town, or Location of Death Landover, MD				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 220-26-8867		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) 9/18/31		9. Birthplace (State or Foreign Country) Eden, MD		
	Usual Residence of Decedent										
10a. State MD		10b. County Prince George's		10c. City, Town or Location Landover				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 1524 Jutewood Avenue				10f. Zip Code 20785				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 4				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Transportation Specialist				16b. Kind of Business/Industry U.S. Government			
17. Father's Name (First, Middle, Last) Louis H. Martin				18. Mother's Name (First, Middle, Maiden Surname) Irene Polk							
19a. Informant's Name/Relationship (Type, Print) Cynthia Briggs/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13206 Strawberry Hill Pl., Clinton, MD 20785							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park			20c. Location - City or Town, State 8/1/00 Landover, MD					
21. Signature of Funeral Service Licensee <i>James H. Bratt</i>				22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., DC 20019							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Carcinoma with Spine (Bone) Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was cause referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>I. Stanley Anderson</i>				29c. License number MD 25528				29d. Date signed (Month, Day, Year) July 28, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I. Stanley Anderson, M.D. 1160 Varnum St., N.E. #216, Wash., D.C. 20017											
31. Date filed (Month, Day, Year) JUL 31 2000				32. Registrar's Signature <i>B. Sports</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(10)

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26036

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED BECKER BUSHMAN

2. Date of Death

JULY 27, 2000 Year

3. Time of Death

2:25PM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

577-10-4270

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 31, 1914

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

VIRGINIA

10b. County

FAIRFAX

10c. City, Town or Location

ANNANDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5109 BLUERIDGE AVENUE

10f. Zip Code

22003

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

Collage (14 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JULIUS T. BECKER

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE CHISUM

19a. Informant's Name/Relationship (Type, Print)

SALLIE MILLER - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5109 BLUERIDGE AVE ANNANDALE, VA 22003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL MEMORIAL PARK

Date

8-1-00

20c. Location - City or Town, State

FALLS CHURCH, VA

21. Signature of Funeral Service Licensee

Diana L. Zeris

22. Name and Address of Facility

DEMAINE FUNERAL HOME

5308 BACKLICK ROAD SPRINGFIELD, VA 22151

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebral vascular accident
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia
Due to (or as a consequence of):

1 month

c. Sepsis
Due to (or as a consequence of):

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles W. Karesch M.D.

29c. License number

D21726

29d. Date signed (Month, Day, Year)

July 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHARLES W. KARESCH- 9701 VEIRS DR., ROCKVILLE, MD.

31. Date filed (Month, Day, Year)

JUL 31 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

2 1/2

1885 10 10

1885 10 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26037

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL ALAN BELL Sr.				2. Date of Death Month Day Year JULY 31 2000		3. Time of Death 6:10 AM	
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 220-38-0977		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) FEBRUARY 23, 1945	
	9. Birthplace (State or Foreign Country) WASH. D.C.		10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location HYATTSVILLE	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MARYLAND				10b. County PRINCE GEORGES		10c. City, Town or Location HYATTSVILLE	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 5510 NEWTON STREET APT 6				10f. Zip Code 20784		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER		16b. Kind of Business/Industry REAL ESTATE			
	17. Father's Name (First, Middle, Last) MONROE REX				18. Mother's Name (First, Middle, Maiden Surname) MILDRED PINKNEY			
	19a. Informant's Name/Relationship (Type, Print) DENISE A BELL (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1227 NALLEY ROAD, LANDOVER MARYLAND 20785			
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CREMATORY		Date 8-5-00		20c. Location - City or Town, State BRENTWOOD, MARYLAND	
	21. Signature of Funeral Service Licensee <i>Ramon Gutierrez</i>				22. Name and Address of Facility FORT LINCOLN FUNERAL HOME INC 3401 BLADENSBURG RD, BRENTWOOD MD 20722			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Aspiration Pneumonia</i> Due to (or as a consequence of): c. <i>Esophageal carcinoma</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia</i>								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>V. P. Chandar M.D.</i>								
29c. License number D16380								
29d. Date signed (Month, Day, Year) 7-31-00								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Venkataraman P. Chandar</i> 6001, Landover Rd, Choverly MD, 20785								
31. Date filed (Month, Day, Year) AUG 03 2000								
32. Registrar's Signature <i>B. G. Spauls</i>								

ORIGINAL

1000000000

[Faint, illegible handwritten text covering the majority of the page]

1000000000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26038

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE VIRGINIA BROWN

2. Date of Death

Month Day Year
August 1 2000

3. Time of Death
1:00 p.m.

4a. Facility Name (If not institution, give street and number)

REGENCY NURSING HOME

4b. City, Town, or Location of Death

FORESTVILLE

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

577 38 3103

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 4, 1912

9. Birthplace (State or Foreign Country)

Bethesda, MD

Usual Residence of Decedent

10a. State
Maryland

10b. County
Prince George's

10c. City, Town or Location
Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6233 Addison Road

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Harvey Simms

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Bundy

19a. Informant's Name/Relationship (Type, Print)

Thelma Washington/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6233 Addison Road Seat Pleasant, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cem

Date

8-7

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Kimberly Bruce-Tome

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MD
4308 Suitland Road Suitland, MD 20746

23a. Pertinent Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ischemic Cardiomyopathy

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George C. Hajjar, Jr.

29c. License number

039550

29d. Date signed (Month, Day, Year)

8-2-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20746

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26039

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE LORETTA BELLOFATTO				2. Date of Death Month Day Year JULY 29 2000		3. Time of Death 11:00 a.m.	
	4a. Facility Name (If not institution, give street and number) 1004 Quietview Drive				4b. City, Town, or Location of Death Capitol Heights		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 096-18-2733	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 28, 1913		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1004 Quietview Drive				10f. Zip Code 20743		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bartender/Waitress		18b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) William Puchalski				18. Mother's Name (First, Middle, Maiden Surname) Eva Baranski			
	19a. Informant's Name/Relationship (Type, Print) Edward Kozireski/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Quietview Drive Capitol Heights, MD 20743			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 8-2-00 Alexandria, Virginia			
	21. Signature of Funeral Service Licensee Edward Kozireski				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, Maryland 20785			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Uremia - Discontinuation of Dialysis Due to (or as a consequence of): End stage renal disease Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Coronary artery disease							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier K. Damack no.				29c. License number D25640		29d. Date signed (Month, Day, Year) August 1, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSROW-DAVACHI, MD 1328 Southern Avenue S.E. Washington DC 20032							
	State Registrar	31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature [Signature]		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26040

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ann K. Bartock

2. Date of Death

July 25 2000

3. Time of Death

2119

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

235-24-3722

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

8. Date of Birth

Dec. 3, 1921

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Md

10b. County

Prince George's

10c. City, Town or Location

Landover Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4709 Cooper Lane

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Program Assistant

16b. Kind of Business/Industry

National Science
Foundation

17. Father's Name (First, Middle, Last)

Joseph Kucbell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Strapec

19a. Informant's Name/Relationship (Type, Print)

Paul F. Bartock, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4709 Cooper Lane, Landover Hills, Md 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cheltenham Md. Veteran's 8/2/00 Cheltenham, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon-Hale Funeral Home
9013 Annapolis Road, Lanham, Md 2070623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Uterine Carcinoma with Metastasis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

July 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvestre, 300 Hospital Drive, Cheverly, Maryland

31. Date filed (Month, Day, Year)

JUL 31 2000

32. Registrar's Signature

20785

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26041

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LYNNE M BOWEN		2. Date of Death Month AUGUST Day 04 Year 2000		3. Time of Death 12:29
	4a. Facility Name (If not institution, give street and number) THE Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 228-62-2153	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs, last birthday) 54 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
	8. Date of Birth (Month, Day, Year) October 15, 1945		9. Birthplace (State or Foreign Country) Virginia		
Usual Residence of Decedent					
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 18807 Fountain Terrace			10f. Zip Code 21742		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) program manager		16b. Kind of Business/Industry C. T. A., Inc.	
17. Father's Name (First, Middle, Last) James Anthony Albano, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Mildred Josephine Albis		
19a. Informant's Name/Relationship (Type, Print) Andrew J. Bowen, IV			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18807 Fountain Terrace Hagerstown, Maryland 21742		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rockland Cemetery		20c. Location - City or Town, State 8/8/00 Rockland, Virginia	
21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>		22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. ARTERIAL THROMBOSIS Due to (or as a consequence of):			Approximate Interval Between Onset and Death 2 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. INTRACRANIAL HEMORRHAGE Due to (or as a consequence of):			3 DAYS
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Thai Nguyen MD</i>		29c. License number Q7328		29d. Date signed (Month, Day, Year) AUGUST 04, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAI NGUYEN 600 NORTH WOLFE STREET BALTIMORE, MD 21287-9106					
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature <i>Sparks</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26042

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blanche Irene BOMBERGER

2. Date of Death
Month Day Year

August 4, 2000

3. Time of Death

8:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

WASHINGTON

5. Social Security Number

216-80-2971

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 17, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11226 Hollywood Rd.

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Roy William

Gower

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mae

Hemphill

19a. Informant's Name/Relationship (Type, Print)

Lindin I. Easterday (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17249 Lappans Rd. Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenlawn Memorial Park August 7, 2000

Date

20c. Location - City or Town, State

Williamsport, MD 21795

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis

2 wks

Due to (or as a consequence of):

b.

Urinary tract infection

3 wks

Due to (or as a consequence of):

c.

Senility

-

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

29b. Signature and Title of certifier

29c. License number

D44996

29d. Date signed (Month, Day, Year)

August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/ 301-432-8470

State
Registrar

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

Zafar Malik

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26043

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Thelma M. Bollinger</i>						2. Date of Death Month <i>August</i> Day <i>10th</i> Year <i>2000</i>		3. Time of Death <i>2:33 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Good Samaritan Hospital</i>						4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>----</i>	
Funeral Director	5. Social Security Number <i>207-30-5243</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>82</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec. 22, 1917</i>		9. Birthplace (State or Foreign Country) <i>PA</i>	
	Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Freeland</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>21204 Middletown Road</i>						10f. Zip Code <i>21053</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>Charles H. Sharnetzka</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Amanda J. Tyson</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Robert A. Bollinger</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21200 Middletown Road Freeland, MD 21053</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i>		Date <i>Aug. 14, 2000</i>		20c. Location - City or Town, State <i>Freeland, MD</i>		
21. Signature of Funeral Service Licensee <i>J.J. Hartenstein</i>						22. Name and Address of Facility <i>J.J. Hartenstein Mortuary, Inc. 24 Second Street New Freedom, PA 17349</i>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Myocardial Infarction</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <i>Less than 2 hours</i>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Quish Tripurani</i>				29c. License number <i>D 30661</i>			29d. Date signed (Month, Day, Year) <i>August 10th 2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>SIREESH TRIPURANI 5601 Loch Raven Blvd. Baltimore, Md - 21239.</i>										
31. Date filed (Month, Day, Year) <i>AUG 17 2000</i>		32. Registrar's Signature <i>Benjamin B. Sparks</i>								

ORIGINAL

August 10, 1961

Dr. J. H. Brown

Hypocentral surface

August 10, 1961

D. J. Brown

Dr. J. H. Brown

Dr. J. H. Brown

Dr. J. H. Brown

Dr. J. H. Brown

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26044

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Harwood Bowers				2. Date of Death Month Day Year July 31, 2000		3. Time of Death 11:35 PM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 579-52-8812		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) September 17, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 45 Southgate Avenue		10f. Zip Code 21401		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1938-68		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Naval Officer		16b. Kind of Business/Industry Military		17. Father's Name (First, Middle, Last) John Treadwell Bowers	
	18. Mother's Name (First, Middle, Maiden Surname) Eveline Green		19a. Informant's Name/Relationship (Type, Print) Barbara Bowers / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Southgate Avenue Annapolis, MD 21401		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		20c. Location - City or Town, State Brentwood, MD		21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Urosepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier [Signature]		29c. License number D55187		29d. Date signed (Month, Day, Year) July 31, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Y. 64 Franklin Street, Annapolis, MD 21401	
	31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature [Signature]		33. Date filed (Month, Day, Year)		34. Registrar's Signature	

ORIGINAL

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "END OF LINE".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26045

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOAN MARIE BRYAN				2. Date of Death Month Day Year AUGUST 1 2000		3. Time of Death 11:07AM																											
	4a. Facility Name (If not institution, give street and number) 3614 KAREN CIRCLE				4b. City, Town, or Location of Death LINKWOOD		4c. County of Death DORCHESTER																											
Funeral Director	5. Social Security Number 214-32-5977		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) JULY 27, 1933																											
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MARYLAND		10b. County DORCHESTER		10c. City, Town or Location LINKWOOD																											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3614 KAREN CIRCLE		10f. Zip Code 21835		10g. Citizen of What Country? USA																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) CARE PROVIDER		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARE PROVIDER		16b. Kind of Business/Industry SELF-EMPLOYED																													
	17. Father's Name (First, Middle, Last) CHESTER CHARLES LAUCK				18. Mother's Name (First, Middle, Maiden Surname) MARIE BISHOP																													
	19a. Informant's Name/Relationship (Type, Print) RHONDA PENNY LITTON/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3614 KAREN CIRCLE, LINKWOOD, MARYLAND 21835																													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS CEM.		Date 8/3/00		20c. Location - City or Town, State BEULAH, MARYLAND																											
	21. Signature of Funeral Service Licenses 				22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207, EAST NEW MARKET MD 21631																													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. PANCREATIC CARCINOMA</td> <td>Approximate Interval Between Onset and Death Six months</td> </tr> <tr> <td>b. Hypertension</td> <td>20 years</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. PANCREATIC CARCINOMA	Approximate Interval Between Onset and Death Six months	b. Hypertension	20 years	c.		d.																		
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c.																																		
d.																																		
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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<table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Funeral Director: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier </td> <td colspan="2">29c. License number D15541</td> <td colspan="2">29d. Date signed (Month, Day, Year) 8/3/2000</td> </tr> <tr> <td colspan="8">30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinodrai Mehta, MD 402 Byrn Street Cambridge MD 21613</td> </tr> </table>								29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Funeral Director: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 				29c. License number D15541		29d. Date signed (Month, Day, Year) 8/3/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinodrai Mehta, MD 402 Byrn Street Cambridge MD 21613										
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State Registrar		31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature 																														

1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26046

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanette Bloodsworth Bell				2. Date of Death Month August Day 2 Year 2000		3. Time of Death 10:30 PM										
	4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester										
Funeral Director	5. Social Security Number 217-10-8906	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 11, 1917	9. Birthplace (State or Foreign Country) Maryland										
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State Maryland	10b. County Dorchester	10c. City, Town or Location Cambridge			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
	10e. Street and Number 503 Burton Avenue			10f. Zip Code 21613		10g. Citizen of What Country? US											
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Hardware Company											
	17. Father's Name (First, Middle, Last) William Bloodsworth				18. Mother's Name (First, Middle, Maiden Surname) Freida Murphy												
	19a. Informant's Name/Relationship (Type, Print) Robert Bell Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Burton Avenue Cambridge, Maryland 21613													
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 8/4/00		20c. Location - City or Town, State Salisbury, Maryland										
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Arteriosclerotic Heart Disease</td> <td rowspan="4">Approximate Interval Between Onset and Death year</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. Coronary Heart Failure</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	Approximate Interval Between Onset and Death year	Due to (or as a consequence of):	b. Coronary Heart Failure	Due to (or as a consequence of):	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	Approximate Interval Between Onset and Death year															
	Due to (or as a consequence of):																
	b. Coronary Heart Failure																
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	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier  MD			29c. License number D 47924		29d. Date signed (Month, Day, Year) 8-3-2000												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN THANWY 300 AURORA STREET CAMBRIDGE MD 21613																	
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature 															

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

copy to send, 10/27/90

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26047

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARL BOOTH				2. Date of Death Month July Day 30 Year 2000		3. Time of Death 2131		
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 217-76-9348		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		6. Date of Birth (Month, Day, Year) Aug 04 1959		
	10a. State Maryland		10b. County Queen Anne		10c. City, Town or Location Queen Anne		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver				16b. Kind of Business/Industry general freight	
17. Father's Name (First, Middle, Last) Harry R. Booth				18. Mother's Name (First, Middle, Maiden Surname) Charlotte A. Greiner Booth					
19a. Informant's Name/Relationship (Type, Print) Charlotte A. Booth/ mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Horseshoe Road Queen Anne, Maryland 21657					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery				20c. Location - City or Town, State 8/2/00 Hillsboro, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio-pulmonary Arrest Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Multi organ Failure Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End-Stage Renal Disease Pulmonary Hypertension				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number 12485	
29d. Date signed (Month, Day, Year) July 30, 2000				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GARY COKE, University of Maryland Medical System, Baltimore, M.D.					
31. Date filed (Month, Day, Year) AUG - 2 2000				32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26048

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHIRLEY A. BRAMBLE				2. Date of Death Month Day Year August 1 2000		3. Time of Death 2305
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot
Funeral Director	5. Social Security Number 215-58-7240	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 4, 1945	9. Birthplace (State or Foreign Country) Delaware
	Usual Residence of Decedent						
10a. State MD		10b. County Caroline		10c. City, Town or Location Federalsburg		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 27995 Bloomery Road				10f. Zip Code 21632		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Prep Cook		16b. Kind of Business/Industry Restaurant	
17. Father's Name (First, Middle, Last) Charles Smith				18. Mother's Name (First, Middle, Maiden Surname) Margaret Smith			
19a. Informant's Name/Relationship (Type, Print) David H. Bramble/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 124, Federalsburg, MD 21632			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bloomery Cemetery		Date 8/4		20c. Location - City or Town, State Federalsburg, MD	
21. Signature of Funeral Service Licensee Michael F. Eckert				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. sepsis Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 4 days 4 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Nancy Snow					
		29c. License number HC05 3369		29d. Date signed (Month, Day, Year) 8/2/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy Snow, M.D., 219 Washington St., Easton, MD 21601							
31. Date filed (Month, Day, Year) AUG - 4 2000		32. Registrar's Signature [Signature]					

Shirley Bramble

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26049

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas Bobyk

2. Date of Death

Month Day Year
AUGUST 7, 2000

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral
Director

5. Social Security Number

045-14-0090

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 19, 1921

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Connecticut

10b. County

Litchfield

10c. City, Town or Location

Terryville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

44 Pearl Street

10f. Zip Code

06786

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
Twelve Years

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

U.S. Treasury Dept.

17. Father's Name (First, Middle, Last)

Michael Bobyk

18. Mother's Name (First, Middle, Maiden Surname)

Anna Wanko

19a. Informant's Name/Relationship (Type, Print)

Mary Bobyk (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

44 Pearl Street, Terryville, Connecticut 06786

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Michael Cemetery

Date

8/10/00

20c. Location - City or Town, State

Terryville, Connecticut

21. Signature of Funeral Service Licensee

Shonaw M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-076623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

30 MINUTES

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. DeLeonis

29c. License number

01049148

29d. Date signed (Month, Day, Year)

AUGUST 7, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

OLAJID ODELOWO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

31. Date filed (Month, Day, Year)

AUG 08 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

NAME KNOWN TO PHYSICIAN: BOBYK, NICHOLAS

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26050

Amended Item #16b per FHG786 8/18/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH B. BEBBER				2. Date of Death Month Day Year July 29, 2000		3. Time of Death 7:20 PM		
	4a. Facility Name (If not Institution, give street and number) 1958 Glen Cove Road				4b. City, Town, or Location of Death Darlington		4c. County of Death Harford		
Funeral Director	5. Social Security Number 218-22-3198		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) 9/23/1912		
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Harford		10c. City, Town or Location Darlington		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1958 Glen Cove Road		10f. Zip Code 21034		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Commodore Hawkins		18. Mother's Name (First, Middle, Maiden Surname) Eliza Reed	
19a. Informant's Name/Relationship (Type, Print) Robert H. Bebbber- son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1958 Glen Cove Rd., Darlington, MD 21034		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery 8/1/00		20c. Location - City or Town, State Darlington, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Harkins F.H. Inc., 600 Main St., Delta, PA 17314		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute myocardial infarction Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier  MD		29c. License number D36425		29d. Date signed (Month, Day, Year) 7/31/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Adam Faill, 206 Hays St, Bel Air, MD		31. Date filed (Month, Day, Year) AUG 2 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

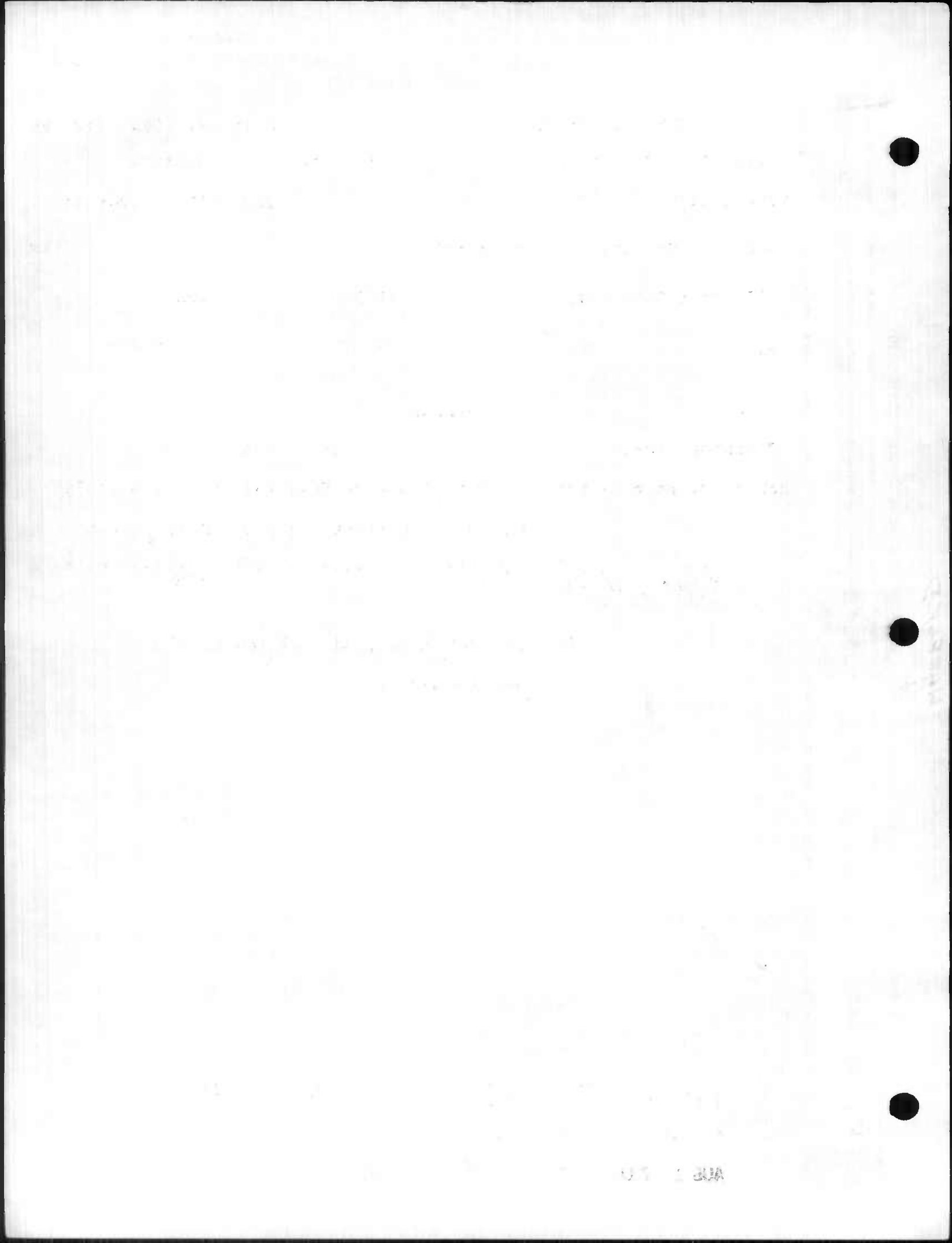
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26051

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Catherine M. Buettner</i>				2. Date of Death Month <i>July</i> Day <i>30</i> , Year <i>2000</i>				3. Time of Death <i>2:20 AM</i>						
	4a. Facility Name (If not institution, give street and number) <i>Gilchrist Center</i>				4b. City, Town, or Location of Death <i>Towson</i>				4c. County of Death <i>Baltimore</i>						
Funeral Director	5. Social Security Number <i>212-05-1290</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>95</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>July 24, 1905</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10a. Street and Number <i>1651 E. Belvedere Ave.</i>				10f. Zip Code <i>21239</i>		10g. Citizen of What Country? <i>U.S.A.</i>								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Grade</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>							
	17. Father's Name (First, Middle, Last) <i>(unknown)</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>(unknown)</i>										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Mr. Charles Wargo (Personal Rep.)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2930 E. Baltimore St., Baltimore, MD 21224</i>										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Green Mount Crematory</i>		Date <i>8/2/00</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>								
	21. Signature of Funeral Service Licensee <i>Brian C. Weillien</i>				22. Name and Address of Facility <i>Schimunek Funeral Home, Inc., 9705 Belair Rd. Baltimore, MD 21236</i>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Aortic stenosis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <i>years</i>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <i>Dr. Anthony Riley, MD</i>		29c. License number <i>025205</i>		29d. Date signed (Month, Day, Year) <i>July 30, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>W.A.R. & G.B.M. 6701 N. Charles St. Balto. Md 21208</i>										31. Date filed (Month, Day, Year) <i>AUG 8 2000</i>		32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26052

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James David Carlton				2. Date of Death Month Day Year July 30, 2000		3. Time of Death 5:45 A.M.		
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare at Layhill				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 409-46-4753	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 13, 1922		9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington, DC Washington, D.C. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1921 Bunker Hill Road		10f. Zip Code 20018		10g. Citizen of What Country? U.S.A.
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer		16b. Kind of Business/Industry U.S. Government				
	17. Father's Name (First, Middle, Last) James David Carlton, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Laura Jones				
	19a. Informant's Name/Relationship (Type, Print) Willette M. Carlton/ wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1921 Bunker Hill Rd. Washington, DC 20018				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory August 1, 2000 Brentwood, MD		20c. Location - City or Town, State		20d. Date		
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. Sepsis Due to (or as a consequence of): Pneumonia		1 week		Approximate Interval Between Onset and Death		
	c. Endocarditis Due to (or as a consequence of):		1 week						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Anurita Mendhiratta MD		29c. License number D38262		29d. Date signed (Month, Day, Year) Aug 1, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D. 2401 Research Blvd. #340 Rockville, MD 20850									
State Registrar	31. Date filed (Month, Day, Year) AUG 03 2000		32. Registrar's Signature B. Spots						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26053

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jessie James Carney				2. Date of Death Month Day Year July 25 2000		3. Time of Death 3:42AM	
	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 243-20-0153	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 28, 1921		9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Greenbelt			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10a. Street and Number 8437 Greenbelt Rd. # T1				10f. Zip Code 20770		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? XX <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) warehouseman			16b. Kind of Business/Industry General Electric		
	17. Father's Name (First, Middle, Last) Johnnie Carney				18. Mother's Name (First, Middle, Maiden Surname) Josephine Plummer			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia Hughes / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8437 Greenbelt Rd. # T1 Greenbelt, MD 20770			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemtery		Date July 31, 2000		20c. Location - City or Town, State Brentwood, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostate Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D43690	
					29d. Date signed (Month, Day, Year) 07/25/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOUSTAFA SHAMMA, MD, 8118 GOOD LUCK RD, LANHAM, MD 20706							
31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26054

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAWRENCE A. CHISLEY				2. Date of Death Month July Day 27 Year 2000		3. Time of Death 8:12am	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death AA COUNTY	
Funeral Director	5. Social Security Number 212-32-9946	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 28 1936		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ODENTON		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number RITA DRIVE				10f. Zip Code 21113		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TREE TRIMMER		16b. Kind of Business/Industry GASPRICH TREE SERVICE		
17. Father's Name (First, Middle, Last) JOHN F. CHISLEY				18. Mother's Name (First, Middle, Maiden Surname) MARTHA CONTEE				
19a. Informant's Name/Relationship (Type, Print) RUTH BELT (SISTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 C WOODHILL DR. GLEN BURNIE, MD. 21061				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) WILSON MEM. CEMETERY		20c. Location - City or Town, State 7/31/00 GAMBRILLS, MD.		
21. Signature of Funeral Service Licensee <i>Larry A. Reese M00483</i>				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. MYOCARDIAL INFARCTION Due to (or as a consequence of):</p> <p>b. CORONARY ARTERY DISEASE Due to (or as a consequence of):</p> <p>c. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of):</p> <p>d. _____</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Ramkr Rastorin</i>				29c. License number 117737		29d. Date signed (Month, Day, Year) 7/31/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMKR RASTORIN, 7575 RITCHIE HWY, G.B. 21061								
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature <i>B. Spence</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26055

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Robert Conley				2. Date of Death Month Day Year August 2, 2000		3. Time of Death 11:20 AM	
	4a. Facility Name (If not institution, give street and number) 1902 Marconi Circle				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 090-16-5950	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 4, 1923	9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. Street and Number 1902 Marconi Circle				10f. Zip Code 21401		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Agent		16b. Kind of Business/Industry Electronics		
17. Father's Name (First, Middle, Last) Joseph M. Conley				18. Mother's Name (First, Middle, Maiden Surname) Anna Jackman				
19a. Informant's Name/Relationship (Type, Print) Mary E. Conley/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Marconi Circle Annapolis, Maryland 21401				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 8-4-00		20c. Location - City or Town, State Crownsville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brain tumor Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 2 mos.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D19838		29d. Date signed (Month, Day, Year) 8/2/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonich, M.D. 900 Bestgate Annapolis, Md. 21401								
State Registrar	31. Date filed (Month, Day, Year) AUG 03 2000		32. Registrar's Signature 					

0005 20 JUA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26056

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL L. CAIN

2. Date of Death

JULY 30 2000

3. Time of Death

1956

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

218-28-8307

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 23 1930 MARYLAND

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1140 MADISON ST. APT. S4

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LAUNDRY ASSISTANT

16b. Kind of Business/Industry

MARRIOTT HOTEL

17. Father's Name (First, Middle, Last)

JAMES E. SNOWDEN SR.

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES BLUNT

19a. Informant's Name/Relationship (Type, Print) IRENE
PATRICIA CAIN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

199 CLAY STREET ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HILL CREST CEMETERY

Date

8/4/00

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Harry A. Reese M00483

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 hr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Renal failure

Due to (or as a consequence of):

2 yrs

c. Hypertension

Due to (or as a consequence of):

18 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

Cardiomyopathy

Renal cell cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James Ruppel

29c. License number

D25499

29d. Date signed (Month, Day, Year)

8/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Ruppel

180 Admiral Cochrane Dr

Annapolis, MD

31. Date filed (Month, Day, Year)

AUG 02 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL

VALLEY HILLS

WASH. D.C. 20540
AUG 8 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26057

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Craig Franklin Carr				2. Date of Death Month: July Day: 30 Year: 2000				3. Time of Death 10:30 P.M.		
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 217-74-6794		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 20, 1955		9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1267 Pine Hill Drive				10f. Zip Code 21401				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) :				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician				16b. Kind of Business/Industry Music			
17. Father's Name (First, Middle, Last) Lester C. Carr				18. Mother's Name (First, Middle, Maiden Surname) Virginia Ann Gravely							
19a. Informant's Name/Relationship (Type, Print) Lester C. Carr/ Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Chesapeake Drive Churchton, MD 20733							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 8-2-00 Alexandria, Virginia					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 7/29/00		28b. Time of Injury 0143 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVER OF AUTO WHICH STRUCK A FIXED OBJECT 28e. Location (Street and Number or Rural Route Number, City or Town, State) MD RT 648 AND FERRY FARM RD, ANNAPOLIS MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) July 31, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenny Mario Costello				2. Date of Death Month August Day 11 Year 2000				3. Time of Death 11:25 A.M.		
	4a. Facility Name (If not institution, give street and number) 107 Georgia Avenue NE #3				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 212-08-0776		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 31 Yrs.		8. Date of Birth (Month, Day, Year) July 23, 1969		9. Birthplace (State or Foreign Country) Germany		
	Usual Residence of Decedent				10a. State Maryland		10b. County Harford		10c. City, Town or Location Edgewood		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 3319 Willoughby Beach Road				10f. Zip Code 21040		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician			
17. Father's Name (First, Middle, Last) Richard Howard Costello				18. Mother's Name (First, Middle, Maiden Surname) Ursula Bridgette Besser				19a. Informant's Name/Relationship (Type, Print) Richard H. Costello- father			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3319 Willoughby Beach Road, Edgewood, Maryland 21040				20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.			
20c. Date 8/15/00				20d. Location - City or Town, State Towson, Maryland				21. Signature of Funeral Service Licensee 			
22. Name and Address of Facility McComas Funeral Home, P.A.				22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC AND COCAINE INTOXICATION			
23b. Approximate Interval Between Onset and Death				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found: 8-10-00				28b. Time of Injury Found: 11:15			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred UNKNOWN				28e. Location (Street and Number or Rural Route Number, City or Town, State) 107 GEORGIA AVE. GLEN BURNIE, MARYLAND			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.			
29d. Date signed (Month, Day, Year) August 11, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201				31. Data filed (Month, Day, Year) AUG 17 2000			
32. Registrar's Signature 											

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26059

Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) Gertrude J. Combs				2. Date of Death Month Day Year July 31, 2000				3. Time of Death 23:25	
	4a. Facility Name (If not Institution, give street and number) Union Hospital of Cecil County				4b. City, Town, or Location of Death Elkton				4c. County of Death Cecil	
Funeral Director	5. Social Security Number 214-20-4796		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) April 16, 1924		9. Birthplace (State or Foreign Country) Tennessee	
	Usual Residence of Decedent				10a. State Maryland		10b. County Cecil		10c. City, Town or Location North East	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 23 Nazarene Church Road				10f. Zip Code 21901	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry In her own home				17. Father's Name (First, Middle, Last) Charles A. Humphrey	
	18. Mother's Name (First, Middle, Maiden Surname) Mammie Church				19a. Informant's Name/Relationship (Type, Print) Amos Combs / Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 371, North East, Maryland 21901	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cemetery				20c. Location - City or Town, State August 4, 2000 North East, Maryland	
	21. Signature of Funeral Service Licensee Robert J. Croun				22. Name and Address of Facility Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxic Ischemic Encephalopathy 3 days Due to (or as a consequence of): Acute Respiratory Failure 3 days Due to (or as a consequence of): Advance Emphysema/COPD 15 years approx. Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier Jayantilal K Patel				29c. License number D22307				29d. Date signed (Month, Day, Year) 8/1/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANTILAL K PATEL, 123 Slingerly Ave, Elkton, MD				31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature Selena S. Sparks		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26060

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RALPH LEE CANTLER				2. Date of Death Month July Day 31 Year 2000				3. Time of Death 9:30 PM	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death HAvre de Grace				4c. County of Death Harford	
Funeral Director	5. Social Security Number 196-18-6658		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 8/3/1923		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10a. State MD		10b. County Cecil		10c. City, Town or Location Port Deposit				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 8 Orchard Drive				10f. Zip Code 21904				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fire Fighter				16b. Kind of Business/Industry Civil Service		
17. Father's Name (First, Middle, Last) George Cantler				18. Mother's Name (First, Middle, Maiden Surname) Emma Smith						
19a. Informant's Name/Relationship (Type, Print) Shirley J. Cantler- wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Orchard Drive, Port Deposit, MD 21904						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Nebo Cemetery		Date 8/4/2000		20c. Location - City or Town, State Delta, PA		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Harkins F.H.Inc., 600 Main St Delta PA 17314						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic CARDIOMYOPATHY Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): c. Rupture of perforated DIVERTICULUM with abscess Due to (or as a consequence of): d.										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION CORONARY ARTERY DISEASE PERIPHERAL VASCULAR DISEASE										
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Hisup Sim		29c. License number 7464/2		29d. Date signed (Month, Day, Year) 8/1/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hisup Sim 319 S. Union Ave Hdb mn 2178										
31. Date filed (Month, Day, Year) AUG 3 2000		32. Registrar's Signature <i>[Signature]</i>								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26061

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanore Loretta Cardiff				2. Date of Death Month Day Year July 31, 2000				3. Time of Death 11:20 PM	
	4a. Facility Name (If not Institution, give street and number) Brooke Grove Assisted Living				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 211-26-6078		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		II Under 1 Year Months Days		II Under 24 Hrs. Hours Min.	
	11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5 Osprey Court				10f. Zip Code 20855		10g. Citizen of What Country? USA			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		Collega (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Nursing	
	17. Father's Name (First, Middle, Last) Bartly Flannery				16. Mother's Name (First, Middle, Maiden Surname) Mary Malia					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Geralyn C. Praskiewicz (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Osprey Court Rockville, MD 20855					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Annunciation Cemetery		Data 8/5/00		20c. Location - City or Town, State Shenandoah Heights, PA			
	21. Signature of Funeral Service Licensee Bursken Amy Ungerlesbee				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399					
	23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier J. Howe MD				29c. License number D33700		29d. Date signed (Month, Day, Year) August 1, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713									
	31. Date filed (Month, Day, Year) AUG 3 2000				32. Registrar's Signature B. Jones					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26062

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jessie W. Dade

2. Date of Death

Month Day Year
July 31 2000

3. Time of Death

1800

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

578-52-1155

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Sep. 4, 1938

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1905 Billings Avenue

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Printing Professional

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Armstead Wells

18. Mother's Name (First, Middle, Maiden Surname)

Martha Lunsford

19a. Informant's Name/Relationship (Type, Print)

Sharon White - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3110 Rose Valley Dr., Ft. Wash., MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

8/5/2000

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Subarachnoid Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Salvador S. Siverter, MD

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

August 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Siverter, 300 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

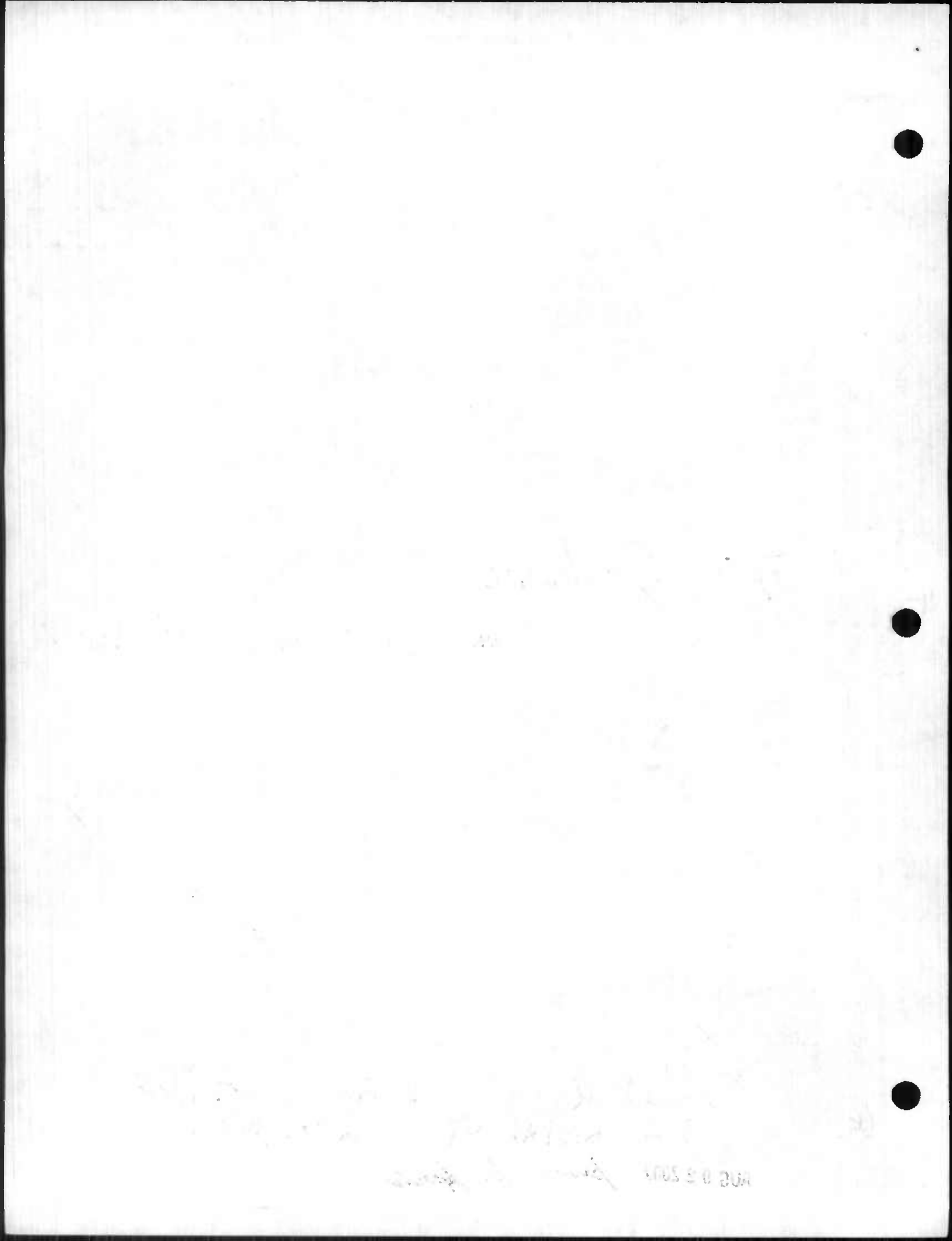
State of Maryland / Department of Health and Mental Hygiene 00 26063

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary E. Donoghue				2. Date of Death Month Day Year July 31 2000				3. Time of Death 3:44 P.M.	
	4a. Facility Name (If not institution, give street and number) 7115 Lory Lane				4b. City, Town, or Location of Death Lanham				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 168 26 5731		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 30, 1932		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Lanham	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 7115 Lory Lane				10f. Zip Code 20706	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home				17. Father's Name (First, Middle, Last) Gerald Marrs	
	18. Mother's Name (First, Middle, Maiden Surname) Helen Walker				19a. Informant's Name/Relationship (Type, Print) Edward I. Donoghue Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7115 Lory Lane Lanham Maryland 20706	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery				20c. Location - City or Town, State Cheltenham Maryland	
	21. Signature of Funeral Service Licensee <i>[Signature]</i> MD1095				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>lung cancer, metastatic</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D-17605				29d. Date signed (Month, Day, Year) 8/1/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.J. HALDAR MD Clinton, MD				31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature <i>[Signature]</i>		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26064

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Simplicio D. Domigge, Sr.			2. Date of Death Month Day Year July 27, 2000		3. Time of Death 10:21 am	
	4a. Facility Name (If not institution, give street and number) 16 Cree Drive			4b. City, Town, or Location of Death Forrest Heights		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-98-9859	6. Sex XX M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 25, 1925	9. Birthplace (State or Foreign Country) Philippine Is.
	Usual Residence of Decedent						
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 16 Cree Dr.			10f. Zip Code 20745		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian/Filipino	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kitchen Attendant		16b. Kind of Business/Industry Hotel Food Service		
17. Father's Name (First, Middle, Last) Isidro Domigge, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Francisca Duran			
19a. Informant's Name/Relationship (Type, Print) Nellie Millando/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7410 Abington Dr. Oxon Hill, Md. 20745			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 7/31/2000		20c. Location - City or Town, State Clinton, Md.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): a. Hanging b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7/27/00		28b. Time of Injury unk M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred Subject hanged self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 Cree Drive 20745	
29a. Certify (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 28, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Laron Locke 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JUL 31 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26065

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ODELLA DORSEY				2. Date of Death Month 7 Day 30 Year 2000		3. Time of Death 5:20 AM	
	4a. Facility Name (If not institution, give street and number) MARKER HEALTH OF BETHESDA				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMARY	
Funeral Director	5. Social Security Number 252-04-5285		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/7/28	9. Birthplace (State or Foreign Country) STATES
	Usual Residence of Decedent							
10a. State D.C.		10b. County		10c. City, Town or Location SOUTH EAST, WASHINGTON D.C.			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 2700 Jasper Place, S.E. #340				10f. Zip Code 20032		10g. Citizen of What Country? United States		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. African American	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Joe Ponder				18. Mother's Name (First, Middle, Maiden Surname) Viola Thrasher				
19a. Informant's Name/Relationship (Type, Print) Roy Holbrook - Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Wythe St., Alexandria, VA 22314				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, MD		
21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ADVANCED LUNG CANCER.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - HYPERTENSION WITH STROKE - PRESSURE SORES, - CONGESTIVE HEART FAILURE								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined				28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier L. Shyam Sundar				29c. License number D0053367		29d. Date signed (Month, Day, Year) 7/30/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810, DARNESTOWN ROAD, SUITE 202, GAITHERSBURG, MD 20878.								
31. Date filed (Month, Day, Year) AUG 0 2 2000				32. Registrar's Signature B. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26066

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys May Douglas

2. Date of Death

Month Day Year
JULY 29 2000

3. Time of Death

11:30A.M

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

577-44-8210

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 5, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37810 Indian Creek Drive

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8thCollege (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Thomas Tawney

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Kerr

19a. Informant's Name/Relationship (Type, Print)

Arthur H. Douglas, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37810 Indian Creek Drive Charlotte Hall, MD 20622

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/3/00

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

S. S. Sitt

22. Name and Address of Facility

Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHERO-SCLEROTIC HEART DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

UREMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. Anmangandla

29c. License number

D-26064

29d. Date signed (Month, Day, Year)

7-30-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIDYASAGAR ANMANGANDLA M.D. P.O. BOX 282 CHARLOTTE HALL MD 20622

31. Date filed (Month, Day, Year)

AUG 01 2000

32. Registrar's Signature

B. S. Sports

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Gladys M. Douglas
Baltimore, Maryland 21215-0020

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26067

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Tobias Leon Davis

2. Date of Death
Month Day Year
Aug. 8, 20003. Time of Death
6:35am

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

567-37-6929

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08-12-1959

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1102 Fairbanks Court

10f. Zip Code

20602

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Marketing Director

16b. Kind of Business/Industry

Financial Company

17. Father's Name (First, Middle, Last)

Noble Davis, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Castor Lania Arthur

19a. Informant's Name/Relationship (Type, Print)

Mary Elizabeth Davis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1102 Fairbanks Court, Waldorf, Maryland 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Trinity Memorial Gardens

Date

August 15, 2000

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A. 20640
4270 Hawthorne Road, Indian Head, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. COLON CANCER
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D28352

29d. Date signed (Month, Day, Year)

8/8/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan M. Mathur, M.D. 3500 Old Washington Rd. Waldorf, MD 20602

State
Registrar

31. Date filed (Month, Day, Year)

AUG 09 2000

32. Registrar's Signature

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26068

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Lee DEAN				2. Date of Death Month Day Year August 6, 2000				3. Time of Death 3:30 a.m.						
	4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington						
Funeral Director	5. Social Security Number 230-30-7894		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) May 16, 1926		9. Birthplace (State or Foreign Country) Virginia						
	Usual Residence of Decedent				10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
10a. State Maryland		10b. County Washington		10e. Street and Number 1500 Pennsylvania Avenue				10f. Zip Code 21742		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) food preparation				16b. Kind of Business/Industry restaurant							
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) Anna Bess McCormick											
19a. Informant's Name/Relationship (Type, Print) Wilma L. Brill - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7736 Pleasant View, Middletown, Va. 22645											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Shenandoah Memorial Park 8-9-00				20c. Location - City or Town, State Frederick Co., Va.							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Minutes					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Quadriplegia										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 3-30-75		28b. Time of Injury unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred fall down concrete steps					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Bufflick Rd., Winchester, VA.											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 		29c. License number D01062		29d. Date signed (Month, Day, Year) August 7, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward W. Ditto, III, M.D., 19011 Orchard Terrace Rd., Hagerstown, Md. 21742															
31. Date filed (Month, Day, Year) AUG 08 2000				32. Registrar's Signature 											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26069

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Richard Snavelly Duffy</u>				2. Date of Death Month <u>August</u> Day <u>05</u> Year <u>2000</u>		3. Time of Death <u>0015</u>		
	4a. Facility Name (If not institution, give street and number) <u>Washington County Hospital</u>				4b. City, Town, or Location of Death <u>Hagerstown</u>		4c. County of Death <u>Washington County</u>		
Funeral Director	5. Social Security Number <u>213-18-8673</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>82</u> Yrs.	If Under 1 Year Months <u> </u> Days <u> </u>	If Under 24 Hrs. Hours <u> </u> Min. <u> </u>	8. Date of Birth (Month, Day, Year) <u>Dec. 16, 1917</u>		
	9. Birthplace (State or Foreign Country) <u>Maryland</u>								
Usual Residence of Decedent									
10a. State <u>Maryland</u>		10b. County <u>Washington Co.</u>		10c. City, Town or Location <u>Hagerstown</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <u>1111 Sunnyside Drive</u>				10f. Zip Code <u>21742</u>		10g. Citizen of What Country? <u>USA</u>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Industrial Engineer Technician</u>		16b. Kind of Business/Industry <u>Federal Government</u>			
17. Father's Name (First, Middle, Last) <u>Richard Duffy</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary E. Snavelly</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Brenda K. Duffy, Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1111 Sunnyside Drive, Hagerstown, Maryland 21742</u>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Rose Hill Cemetery</u>		Data <u>Aug. 8</u>		20c. Location - City or Town, State <u>Hagerstown, Maryland</u>			
21. Signature of Funeral Service Licensee <u>Douglas A. Fiery</u>				22. Name and Address of Facility <u>Douglas A. Fiery Funeral Home</u> <u>1331 Eastern Blvd. N., Hagerstown, Maryland 21742</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)		a. <u>Acute Pulmonary Embolus</u> minutes							
		Due to (or as a consequence of):							
		b. <u>Acute and Chronic Respiratory Disease</u> 10 days							
		Due to (or as a consequence of):							
		c. <u>Ruptured Aneurysm Aortic Artery Surgery</u> 15 days							
		Due to (or as a consequence of):							
		d.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <u>Karl P. Riddle</u>				29c. License number <u>D38764</u>		29d. Date signed (Month, Day, Year) <u>8/6/00</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Karl P. Riddle 1110 Medical Campus Rd. Suite 100 Hagerstown MD 21742</u>									
31. Date filed (Month, Day, Year) <u>AUG 08 2000</u>		32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified immediately.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Richard Snavelly Duffy
Division of Vital Records, P.O. Box 68760,

NAME: DUFFY,RICHARD SNAVELY
12/16/1917 82 / M

DOS: 07/18/2000
RIGGLE,KARL P.



H3041887864



H307569

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26070

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CARRIE C. DOW				2. Date of Death Month Day Year JULY 26 2000				3. Time of Death 9:55 am			
	4a. Facility Name (If not Institution, give street and number) ANNAPOLIS NURSING & REHAB. CENTER				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 220-16-8887		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 106 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 26 1894		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent				10a. State MARYLAND				10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS	
To Be Completed by Funeral Director	10e. Street and Number 962 OLD ANNAPOLIS NECK ROAD				10f. Zip Code 21403				10g. Citizen of What Country? USA		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK				16b. Kind of Business/Industry CAPITAL RESTAURANT			
	17. Father's Name (First, Middle, Last) WILLIAM BROOKS				18. Mother's Name (First, Middle, Maiden Surname) ROSIE UNOBTAINABLE							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SARAH A. HAMMOND (GRANDDAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1243 CROWS NEST CT. ANNAPOLIS, MD. 21403							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BREWER HILL CEMETERY				20c. Location - City or Town, State 8/1/00 ANNAPOLIS, MD.			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Larry S. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): aspiration pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								Approximate Interval Between Onset and Death 36 h 36 h			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
					24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D 21438				29d. Date signed (Month, Day, Year) Jul 27 2000			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MICHAEL J. LAPEL TA 1016 N RIDGEWAY AVE STE 120 ANNAPOLIS MD 21401											
State Registrar	31. Date filed (Month, Day, Year) JUL 31 2000				32. Registrar's Signature B. Smith							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

0005 1 2 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26071

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Clifford Dew

2. Date of Death

August 2 2000

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

Talbot Hospice House

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

213-22-5056

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

January 31, 1928

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

28515 Oakmont Drive

10f. Zip Code

21601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1946
1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11 HS Grad.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/operator

16b. Kind of Business/Industry

Trucking Company

17. Father's Name (First, Middle, Last)

Raymond Charles Dew

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Thawley

19a. Informant's Name/Relationship (Type, Print)

Dorothy M. Dew Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28515 Oakmont Drive, Easton, Maryland 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capitol Crematory

Date

8/3/2000

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

David H. Smith

22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prostate Cancer.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David H. Smith

29c. License number

D39887

29d. Date signed (Month, Day, Year)

8/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H. Smith, M.D. - 29466 Pintail Drive, Suite #5 Easton, MD 21601

31. Date filed (Month, Day, Year)

AUG - 4 2000

32. Registrar's Signature

R. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26072

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry S. Darlington, III				2. Date of Death Month August Day 2 Year 2000		3. Time of Death 00:15		
	4a. Facility Name (If not institution, give street and number) 116 Park Towne Drive				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 194-32-3137		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) NOV 19, 1941		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 116 Park Towne Drive		10f. Zip Code 21921		
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Year or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Assurance Manager				16b. Kind of Business/Industry Tool and Die Shop				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Henry S. Darlington, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Sara Moore				
	19a. Informant's Name/Relationship (Type, Print) Rose M. Gatta Darlington/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Park Towne Drive, Elkton, Maryland 21921				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hockessin Crematory		20c. Location - City or Town, State Hockessin, Delaware		
	21. Signature of Funeral Service Licensee Donald S. Hicks				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 year							Approximate Interval Between Onset and Death 1 year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier H. Farakas, MD	
	29c. License number D15314							29d. Date signed (Month, Day, Year) Aug 2, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. Farakas, MD VNA / Northern Chesapeake Hospice, Elkton, MD							31. Date filed (Month, Day, Year) AUG 04 2000	
	32. Registrar's Signature B. Sparks							33. State Registrar	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 8 per fh G787 9/21/00 yf

State of Maryland / Department of Health and Mental Hygiene 00 26073

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Virginia Duncan				2. Date of Death Month Day Year July 28 2000				3. Time of Death 0958A	
	4a. Facility Name (If not institution, give street and number) Mariner Health of Bel Air				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford	
Funeral Director	5. Social Security Number 031-18-2224		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Sept. Aug. 3, 1913		9. Birthplace (State or Foreign Country) Mass.	
	Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 22521 Sweetleaf Lane				10f. Zip Code 20882		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business/Industry Education			
17. Father's Name (First, Middle, Last) Hilbert Nelson						18. Mother's Name (First, Middle, Maiden Surname) Emma Pearson				
19a. Informant's Name/Relationship (Type, Print) Peter Hartwell (Nephew)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22521 Sweetleaf Ln., Gaithersburg, MD 20882					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc.		Date 8/2/00		20c. Location - City or Town, State West Chester, PA			
21. Signature of Funeral Service Licensee Kursen Doyle Unlesbee					22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death 5 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier MD					29c. License number D34652			29d. Date signed (Month, Day, Year) July 28, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Scott Hoswell 2 North Avenue Bel Air Maryland 21014										
31. Date filed (Month, Day, Year) AUG 2 2000			32. Registrar's Signature G. Spade							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

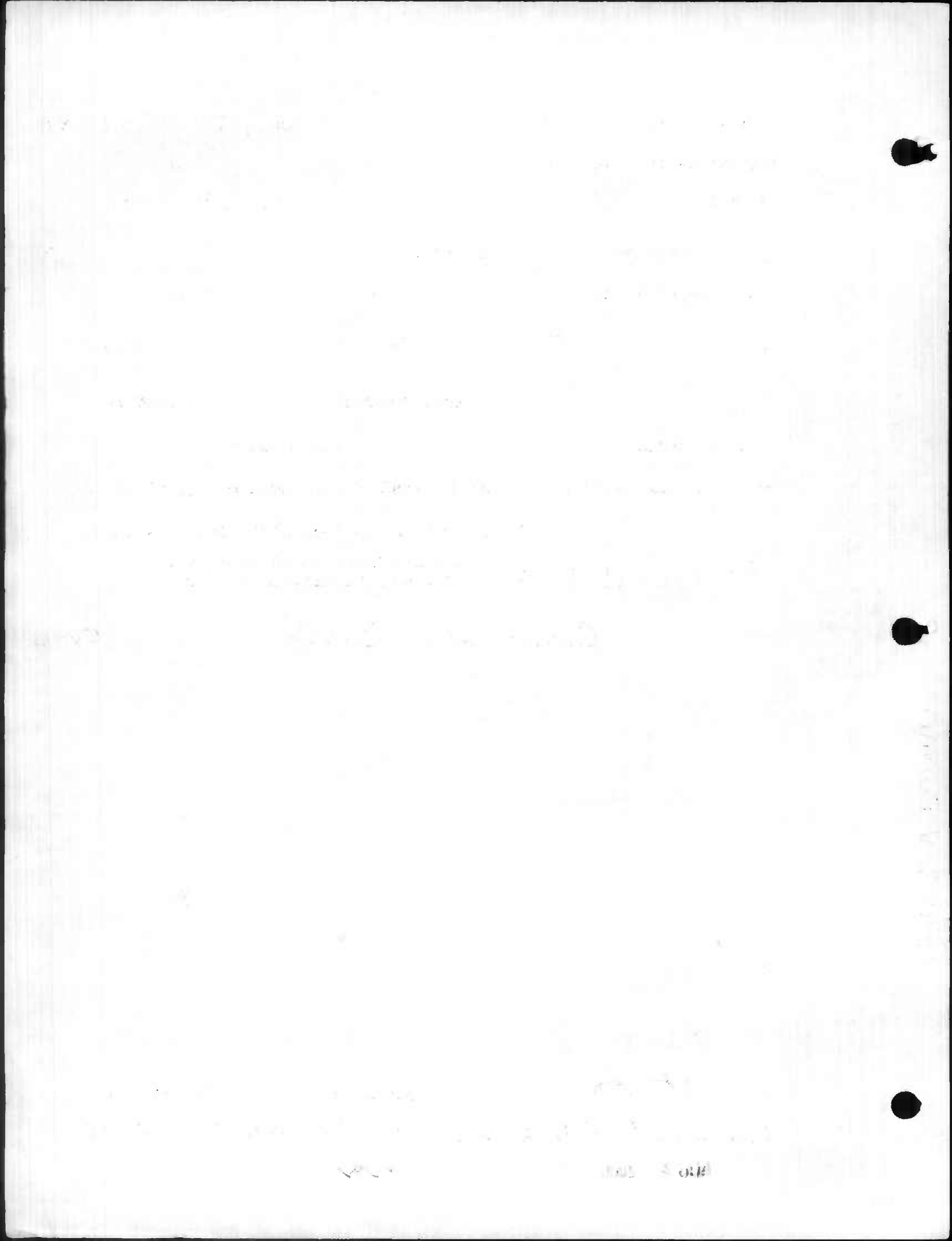
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26074

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Lee ELGIN				2. Date of Death Month Day Year August 2, 2000				3. Time of Death 0325										
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington										
Funeral Director	5. Social Security Number 219-20-2047		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 26, 1926		9. Birthplace (State or Foreign Country) Maryland										
	Usual Residence of Decedent																		
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
10e. Street and Number 57 S. Colonial Drive				10f. Zip Code 21740				10g. Citizen of What Country? USA											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) fire truck driver				16b. Kind of Business/Industry city fire dept.											
17. Father's Name (First, Middle, Last) Albert M. Elgin				18. Mother's Name (First, Middle, Maiden Surname) Mazie Woods															
19a. Informant's Name/Relationship (Type, Print) Loreda V. Elgin - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 S. Colonial Drive, Hagerstown, Md. 21740															
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date 8-5-00		20c. Location - City or Town, State Hagerstown, Maryland											
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Pneumonia</td> <td rowspan="4"> Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease c. Multiple Sclerosis d. Congestive Heart Failure </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pneumonia	Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease c. Multiple Sclerosis d. Congestive Heart Failure	b.		c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pneumonia	Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease c. Multiple Sclerosis d. Congestive Heart Failure																
	b.																		
	c.																		
	d.																		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
Diabetes Mellitis																			
Right Upper Lobectomy for Lung Cancer																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 				29c. License number D52323				29d. Date signed (Month, Day, Year) 8/2/00											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khacid Waseem, M.D., 19414-C Leitersburg Pike, Hagerstown, Md. 21742																			
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26075

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD FLOWERS, JR.				2. Date of Death Month Day Year July 31 2000		3. Time of Death 1535	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 578 90 7042		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) October 6, 1972	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Cheverly	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2415 59th Avenue		10f. Zip Code 20785		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled		16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) Harold Flowers		18. Mother's Name (First, Middle, Maiden Surname) Rosa M. Jordan					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Harold Flowers, Sr./father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 59th Avenue Cheverly, MD 20785			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 8-7	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Kimberly Bruce-Tomic</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Human Immunodeficiency Virus Due to (or as a consequence of): d.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>James Catavenis</i>				29c. License number D30318		29d. Date signed (Month, Day, Year) 7/31/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James Catavenis, MD 3001 Hospital Drive Cheverly, MD 20785							
	31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature <i>Bruce B. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

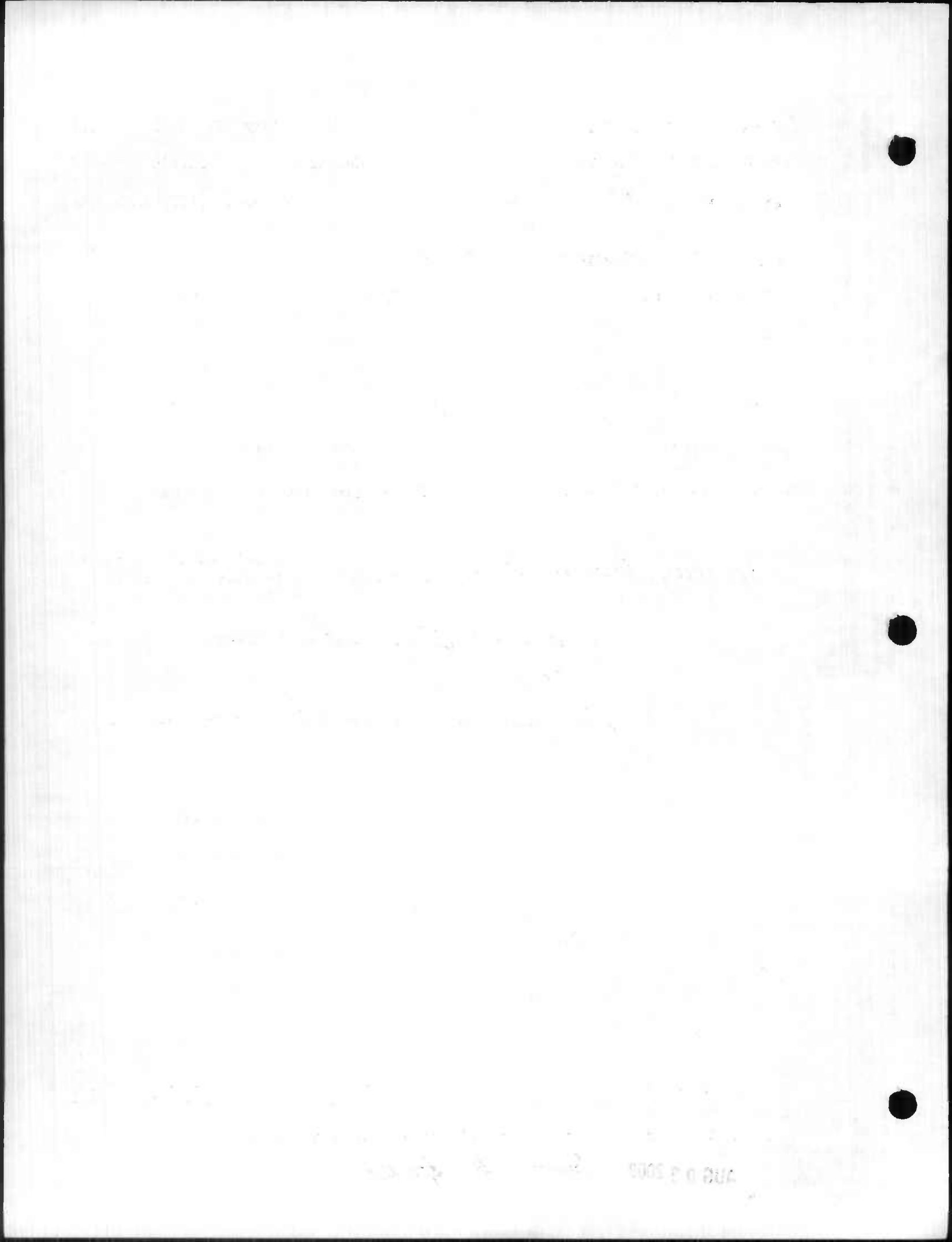
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gracie L. Frazier				2. DATE OF DEATH MONTH 7 DAY 27 YEAR 2000		3. TIME OF DEATH 12:55 P. M	
4. SOCIAL SECURITY NUMBER 223-26-7445		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11- 22- 1917	
8. BIRTHPLACE (State or Foreign Country) Halifax, VA				9a. FACILITY NAME (If not Institution, give street and number) Mariner Health of Bethesda		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE MD		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION 5721 Grosvenor Lane, Bethesda				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5721 Grosvenor Lane	
10f. ZIP CODE 20814				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) College				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Cleaning	
17. FATHER'S NAME (First, Middle, Last) Hurley Hawkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia Anna Comer			
19a. INFORMANT'S NAME (Type/Print) Preston Hawkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 Balfour Drive, Hyattsville, MD 20782			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetary		20c. LOCATION — City or Town, State 8/3/00 Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bernie L. Frazier</i>				22. NAME AND ADDRESS OF FACILITY James E. Vann Funeral Home 4804 Ga. Ave. N. W., Wash., D. C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → gastrointestinal malignancy							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Goldstein</i>				29c. LICENSE NUMBER D03581		29d. DATE SIGNED (Month, Day, Year) Aug 2 2000	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Goldstein 9410 Old Georgetown Rd. Bethesda, Md.							
31. DATE FILED (Month, Day, Year) AUG 03 2000				32. REGISTRAR'S SIGNATURE <i>Bernie L. Frazier</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26077

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nora Lee Foltz

2. Date of Death

August

Day

4 2000

Year

3. Time of Death

1625

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

WASHINGTON

Funeral
Director

5. Social Security Number

216-80-2824

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 1, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

501 Claire Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Edgar

Lee

Hensley

Rosalie

Morris

19a. Informant's Name/Relationship (Type, Print)

Ray E. Foltz (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17510 Virginia Ave. Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park August 8, 2000

Date

20c. Location - City or Town, State

Hagerstown, MD 21740

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atherosclerotic Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Pancreatitis

Hepatitis, nonviral

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DINO J. DELAPORTAS MD 1110 MEDICAL CENTER HAGERSTOWN, MD 21740

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

D. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Nora Lee Foltz

00 26078

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26079

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gregorio Gonzalez

2. Date of Death

Month Day Year
7/30/2000

3. Time of Death

07:05 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

217-21-8664

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2/16/1934

9. Birthplace (State or Foreign Country)

San Salvador

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1713
Yales Place

10f. Zip Code

20850

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify:
Salvadoran14. Race - American Indian,
Black, White, etc.Specify:
Hispanic15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Warehouse

17. Father's Name (First, Middle, Last)

Simeon Gonzalez

18. Mother's Name (First, Middle, Maiden Surname)

Celsa Hernandez

19a. Informant's Name/Relationship (Type, Print)

Mirna Mejia, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 Wellow Dale, Frederick, MD 21072

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gates of Heaven

Date

8/5/00 Silver Springs

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Taylor's Funeral Home

1722 N. Capitol St., NW, Wash., DC 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Carcinoma of Unknown Primary

6 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

7/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road
Mark S. Godec, M.D., Casey House, Rockville, MD 20855

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 04 2000

Mark S. Godec

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26080

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Blair Garrett				2. Date of Death Month Day Year July 29 2000				3. Time of Death 11:37 A.M.		
	4a. Facility Name (If not institution, give street and number) Fort Washington Medical Center				4b. City, Town, or Location of Death Fort Washington				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 212-48-2731		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 10, 1946		9. Birthplace (State or Foreign Country) San Antonio, TX		
	Usual Residence of Decedent				10c. City, Town or Location Oxon Hill		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. State Maryland		10b. County Prince George's		10f. Zip Code 20745				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 6/5/70 1/15/80		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Programmer				16b. Kind of Business/Industry IBM			
17. Father's Name (First, Middle, Last) J. Blair Garrett				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Walker							
19a. Informant's Name/Relationship (Type, Print) Charlotte W. Garrett/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 7/31/2000				20c. Location - City or Town, State Alexandria, VA.			
21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. <u>OCCLUSIVE PULMONARY THROMBOEMBOLISM</u> Due to (or as a consequence of): b. <u>DEEP LEG VEIN THROMBOSIS</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>J.A. P. M.D.</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 30, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MARY G. RIPLEY, M.D.</u> 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature <i>B. Spotts</i>							

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26081

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Earle Godwin		2. Date of Death Month Day Year July 29 2000		3. Time of Death 7:30 PM
	4a. Facility Name (If not Institution, give street and number) 10518 Nast Drive		4b. City, Town, or Location of Death Cheltenham		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 220-12-1259	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In y/s. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 29, 1915		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Cheltenham		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 10518 Nast Drive		10f. Zip Code 20623		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Helen Cole		
	19a. Informant's Name/Relationship (Type, Print) Margaret Godwin Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10518 Nast Dr. Cheltenham, Maryland 20623		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Vets. Cemetery		20c. Location - City or Town, State Cheltenham, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, Maryland		
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>stroke</u> Due to (or as a consequence of): b. <u>atherosclerosis</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's</u> <u>atrial fibrillation</u> <u>Cancer Bladder - Prostate</u>				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number 22259		29d. Date signed (Month, Day, Year) July 31 '00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene Grace MD 9131 Piscataway Rd Clinton, MD 20735				
31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26082

Amend #'s 17.& 18. Per Fam.PGC 8-14-2000 cr Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Marie Gainer				2. Date of Death Month Day Year July 29, 2000		3. Time of Death 4:03a.m.	
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 227-34-6859	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 11, 1928		9. Birthplace (State or Foreign Country) Halifax, Va.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Prince Georges	10c. City, Town or Location Cheverly			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6413 Landover Road			10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Film Cleaning			16b. Kind of Business/Industry Photo Plant		
	17. Father's Name (First, Middle, Last) Kenneth Simms Sanford				18. Mother's Name (First, Middle, Maiden Surname) Katie Sanford Simms			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Eddie W. Gainer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6413 Landover Rd., Cheverly, Md. 20785			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) No. Va. Crematory		Date 8-1-00		20c. Location - City or Town, State Arlington, Va.	
	21. Signature of Funeral Service Licensee <i>Phillip Bell</i>				22. Name and Address of Facility Phillip Bell Funeral Service 4902 Stan Haven Rd., Temple Hills, Md. 20748			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Diabetes, Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Phillip MD</i>		29c. License number D18104		29d. Date signed (Month, Day, Year) 7 31 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMMACK SURV MD. 6005 Landover Road Cheverly Md 20785								
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26083

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William C. Gleeson			2. Date of Death Month Day Year July 28 2000		3. Time of Death 2145													
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death													
Funeral Director	5. Social Security Number 168-40-2731	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/17/1948	9. Birthplace (State or Foreign Country) Pennsylvania												
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State Maryland	10b. County	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
	10e. Street and Number 3900 Loch Raven Blvd.			10f. Zip Code 21218		10g. Citizen of What Country? USA													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1970-1980		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Noncommissioned Officer		16b. Kind of Business/Industry US Army														
	17. Father's Name (First, Middle, Last) Bill Gleeson			18. Mother's Name (First, Middle, Maiden Surname) Hilda Correll															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Benjamin Gleeson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19415 Caravan Dr. Germantown, MD. 20874															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Date 08/14/00	20c. Location - City or Town, State Arlington, Virginia													
	21. Signature of Funeral Service Licensee Michael W. Napper		22. Name and Address of Facility Advent Funeral & Cremation Svcs 7211 Lee Highway Falls Church, Virginia 22046																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sepsis</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 day</td> </tr> <tr> <td>b. Pneumonia</td> <td>Due to (or as a consequence of):</td> <td>2 day</td> </tr> <tr> <td>c. Decubitus Ulcer</td> <td>Due to (or as a consequence of):</td> <td>3 mo</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 day	b. Pneumonia	Due to (or as a consequence of):	2 day	c. Decubitus Ulcer	Due to (or as a consequence of):	3 mo	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 day																
	b. Pneumonia	Due to (or as a consequence of):	2 day																
	c. Decubitus Ulcer	Due to (or as a consequence of):	3 mo																
	d.	Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier Allen G. Garrison MD		29c. License number 2438946-A12		29d. Date signed (Month, Day, Year) July 28, 2000															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen G. Garrison MD 201 E. University Parkway Baltimore MD 21218																			
State Registrar	31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature B. Sparks																

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State of Maryland / Department of Health and Mental Hygiene

00 26084

AMend# 1 per Phy 8/4/00 AACO HEALTH CMH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Lois Joyce Gleaves</u>		2. Date of Death Month <u>July</u> Day <u>30</u> Year <u>2000</u>		3. Time of Death <u>4:41A</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>579-96-7194</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>56</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>Dec 21, 1943</u>		9. Birthplace (State or Foreign Country) <u>China</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Arnold</u>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <u>840 Meadow Heights Lane</u>		10f. Zip Code <u>21012</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>Asian</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>2</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Secretary</u>		16b. Kind of Business/Industry <u>Research</u>	
17. Father's Name (First, Middle, Last) <u>Antonio P. Xavier</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Gertrudes M. Desouza</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Frank Gleaves/Husband</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>840 Meadow Heights Lane, Arnold, MD 21012</u>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <u>Barranco & Sons, P.A. Severna Park Funeral Home</u> <u>495 Gov. Ritchie Hwy Severna Park, MD 21146</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>End-stage Cardiomyopathy</u>		~ 2 years	
		Due to (or as a consequence of):			
		b. <u>Coronary artery disease</u>		~ 1 year	
		Due to (or as a consequence of):			
		c. <u>Renal dysfunction</u>		~ 1 week	
		Due to (or as a consequence of):			
		d. <u>Severe obstructive pulmonary disease</u>		~ 1 year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<u>Tetralogy of Fallot</u>					
<u>Ventricular Tachycardia</u>					
<u>Atrial Flutter and Fibrillation</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Ardehali, MD, PhD</u>		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>07/30/2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>H. Ardehali, MD, PhD, Johns Hopkins Hospital, Baltimore, MD 21205</u>					
31. Date filed (Month, Day, Year) <u>AUG 02 2000</u>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26085

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gertrude D. Glasby</i>				2. Date of Death Month <i>8</i> Day <i>5</i> Year <i>00</i>		3. Time of Death <i>8:55 Am</i>										
	4a. Facility Name (If not institution, give street and number) <i>Northampton Manor</i>				4b. City, Town, or Location of Death <i>Fredrick</i>		4c. County of Death <i>Fredrick</i>										
Funeral Director	5. Social Security Number <i>322-24-8550</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>89</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 24, 1911</i>										
	9. Birthplace (State or Foreign Country) <i>Illinois</i>		10a. State <i>FL</i>		10b. County <i>Collier</i>		10c. City, Town or Location <i>Naples</i>										
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>83 Cotton Wood Lane</i>		10f. Zip Code <i>33962</i>											
10g. Citizen of What Country? <i>U.S.A.</i>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:											
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Book Keeper</i>		16b. Kind of Business/Industry <i>Retail Store</i>											
17. Father's Name (First, Middle, Last) <i>Albert Dambacher</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Pauline Heym</i>													
19a. Informant's Name/Relationship (Type, Print) <i>Robert Glasby (Son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4800 Great Oak Rd. Rockville, Md. 20853</i>													
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Smithsburg Crematory</i>		Date <i>Aug. 9, 2000</i>		20c. Location - City or Town, State <i>Smithsburg, Md.</i>											
21. Signature of Funeral Service Licensee <i>Ernie L. Davis</i>				22. Name and Address of Facility <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { e. b. c. d. </td> <td> <i>Cerebrovascular Accident</i> Due to (or as a consequence of): </td> <td> <i>2 weeks</i> </td> </tr> <tr> <td> <i>Atherosclerosis</i> Due to (or as a consequence of): </td> <td> <i>years</i> </td> </tr> <tr> <td> <i>Hypertension</i> Due to (or as a consequence of): </td> <td> <i>years</i> </td> </tr> <tr> <td> Due to (or as a consequence of): </td> <td> </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{ e. b. c. d.	<i>Cerebrovascular Accident</i> Due to (or as a consequence of):	<i>2 weeks</i>	<i>Atherosclerosis</i> Due to (or as a consequence of):	<i>years</i>	<i>Hypertension</i> Due to (or as a consequence of):	<i>years</i>	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{ e. b. c. d.	<i>Cerebrovascular Accident</i> Due to (or as a consequence of):	<i>2 weeks</i>														
		<i>Atherosclerosis</i> Due to (or as a consequence of):	<i>years</i>														
		<i>Hypertension</i> Due to (or as a consequence of):	<i>years</i>														
		Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Osteoporosis</i>																	
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <i>Ernie L. Davis MD</i>				29c. License number <i>DH7556</i>		29d. Date signed (Month, Day, Year) <i>8/5/00</i>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>William H. Johnson MD, Suite 202, 172 Thomas Johnson Drive Frederick MD 21702</i>																	
31. Date filed (Month, Day, Year) <i>AUG 17 2000</i>		32. Registrar's Signature <i>James B. Sparks</i>															

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26086

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Virginia Gledhill

2. Date of Death

July 27 00 10:08

3. Time of Death

4a. Facility Name (If not institution, give street and number)

LORien Nursing & Rehab Center

4b. City, Town, or Location of Death

Columbia

County of Death

Howard

5. Social Security Number

216-16-6556

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/16/22

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Juliet Lane

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th Grade

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Summa)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Russell W. Gledhill (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8416 Timberland Circle, Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

7/31/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Colon Carcinoma

Due to (or as a consequence of):

Diabetes Mellitus

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home

26. Place of Death (Check only one)

5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D42465

29d. Date signed (Month, Day, Year)

July 27, 2000.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Sam MD 2 Knoll North Dr Columbia MD 21045

31. Date filed (Month, Day, Year)

AUG 3 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text at the top of the page, possibly a title or header, including the word "Introduction".

Main body of handwritten text in the upper section, consisting of several lines of cursive script.

Main body of handwritten text in the lower section, continuing the cursive script across multiple lines.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26087

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Richard Hooper				2. Date of Death Month Day Year August 2 2000		3. Time of Death 7:25PM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 217-14-7194		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 11, 1914	
	9. Birthplace (State or Foreign Country) Virginia		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 206 Ascot Place, N.E.		10f. Zip Code 20002	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Richard Hooper	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Mary Johnson				19a. Informant's Name/Relationship (Type, Print) Hurley T. Hooper - Nephew		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1280 Daingerfield Landing, Champlain, VA 22438	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Park Maryland National Mem.		20c. Location - City or Town, State 8/8/2000 Laurel, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John T. Stewart III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 29c. License number D42403 29d. Date signed (Month, Day, Year) 8-3-2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJ MATHUR 106 IRVING STREET, NW WASHINGTON DC 20010				31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature B. Smith	
	33. Date of Death (Month, Day, Year) AUG 04 2000				34. Registrar's Signature B. Smith		35. Date of Death (Month, Day, Year) AUG 04 2000	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26088

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lola Mae Haynes					2. Date of Death Month Day Year July 29 2000			3. Time of Death 1050	
	4a. Facility Name (If not institution, give street and number) 5703 Birch View Place					4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 144 12 1805		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) March 28, 1912		9. Birthplace (State or Foreign Country) Florida	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State New Jersey		10b. County Monmouth		10c. City, Town or Location Freehold				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5 Avenue A				10f. Zip Code 07728		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aid			16b. Kind of Business/Industry Nursing Home		
	17. Father's Name (First, Middle, Last) Roland Pompey					18. Mother's Name (First, Middle, Maiden Surname) Ida Sheffield				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Pequoia Evans (DAUGHTER)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5703 Birchview Place, Clinton, Maryland 20735				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Lukes Church Cemetery			20c. Location - City or Town, State Vernon, Florida		20d. Date Aug 5, 2000		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Daughter's Home</u>				
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>[Signature]</i>					29c. License number H0055927		29d. Date signed (Month, Day, Year) August 2, 2000		
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) SALVADOR SYLVESTER 300 Hospital Drive, Cheverly, Maryland 20785									
31. Date filed (Month, Day, Year) AUG 02 2000					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26089

Amend# 26, Per Phys. PGC 8-2-2000

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Arthur Hawkins

2. Date of Death

7/29/2000

3. Time of Death

10:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

722 Gleneagles Drive

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

PG

5. Social Security Number

219-34-8339

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-17-37

9. Birthplace (State or Foreign Country)

Pomfret, MD.

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

XXXX 2 No

10e. Street and Number

722 Gleneagles Drive

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hairstylist

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Alex Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Rose M. Hall

19a. Informant's Name/Relationship (Type, Print)

Joyce Hawkins/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

722 Gleneagles Drive Ft. Washington, Md.

20a. Method of Disposition

X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection

Date

8/4/00

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Reginald E. Collier

22. Name and Address of Facility

Wm. F. Magruder FH 2311 MLK Jr. Ave. SE WDC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Failure to Thrive

Due to (or as a consequence of):

b.

Renal Failure

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0046374

29d. Date signed (Month, Day, Year)

8/1/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328 Southern Avenue SE #312 Washington DC 20032

31. Date filed (Month, Day, Year)

AUG 02 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26090

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Amy Josephine Hart						2. Date of Death Month Day Year July 31 2000			3. Time of Death 5:25 AM			
	4a. Facility Name (If not Institution, give street and number) Mariner Health of Forest Hill						4b. City, Town, or Location of Death Forest Hill			4c. County of Death Harford			
Funeral Director	5. Social Security Number 218-16-0073		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) July 3, 1923	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent												
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 1106 Volos Court						10f. Zip Code 21015			10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Government				
17. Father's Name (First, Middle, Last) George Brooks, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Susie Hill							
19a. Informant's Name/Relationship (Type, Print) Rosetta Phillips/Sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Volos Court, Bel Air, Maryland 21015							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery				Date 08/04 2000		20c. Location - City or Town, State Suitland, Maryland			
21. Signature of Funeral Service Licensee Nancy A. Perante						22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier D. C. Miller						29c. License number D22975			29d. Date signed (Month, Day, Year) 8/1/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy A. Perante 615 Macphail Rd Bel Air MD 21014													
31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature B. Spahr									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

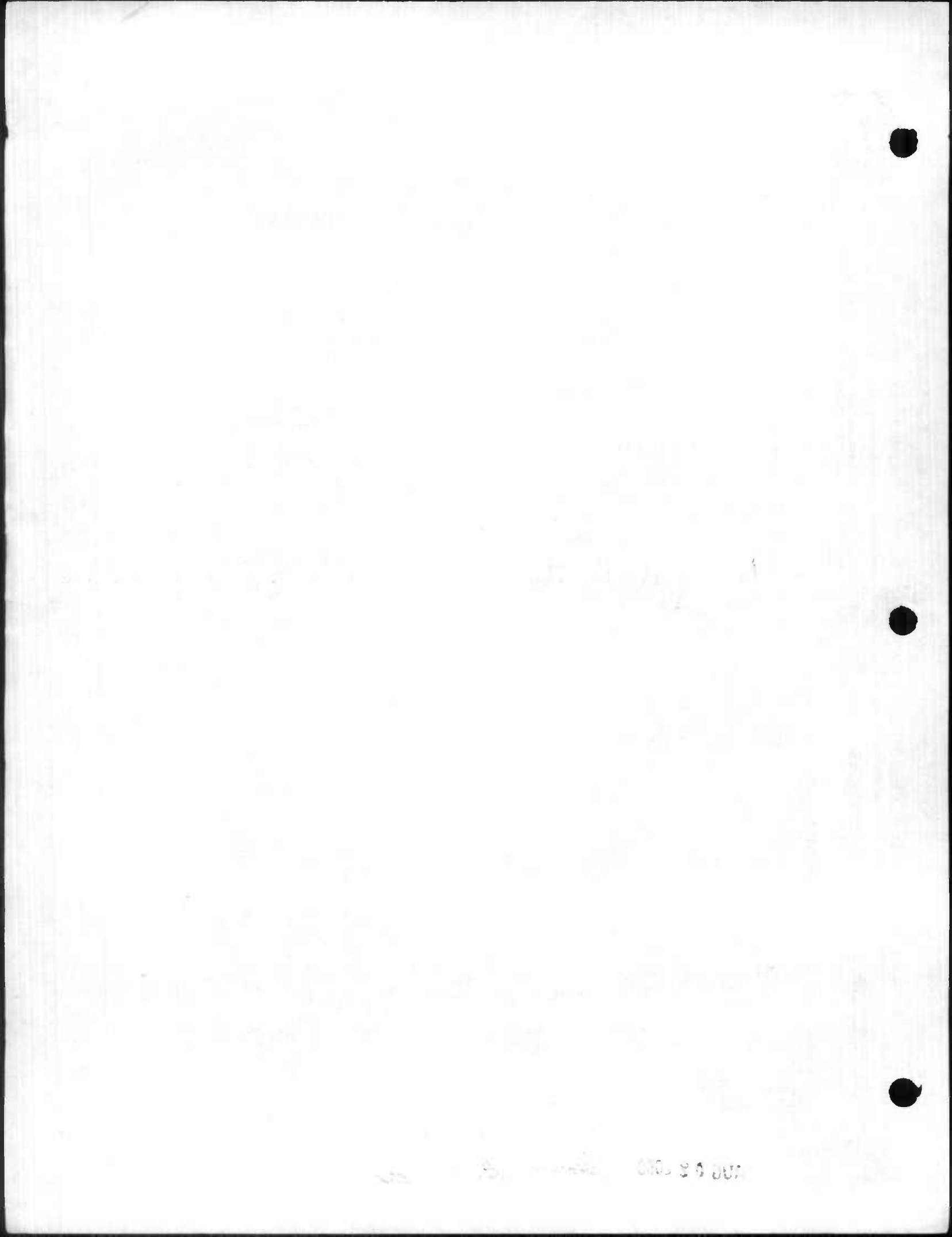
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26091

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Myrtle G. Hunt		2. Date of Death Month Day Year JULY 30, 2000		3. Time of Death 5:05AM					
	4a. Facility Name (If not institution, give street and number) Doctors Hospital		4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's					
Funeral Director	5. Social Security Number 419-10-2255	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	8. Date of Birth (Month, Day, Year) July 12, 1904	9. Birthplace (State or Foreign Country) South Carolina					
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Temple Hills		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 2511 Afton St.		10f. Zip Code 20748		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian		16b. Kind of Business/Industry Federal Government					
	17. Father's Name (First, Middle, Last) Robert Golden		18. Mother's Name (First, Middle, Maiden Surname) Annie Whitaker							
	19a. Informant's Name/Relationship (Type, Print) Michael Moran/Executor		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 Afton St., Temple Hills, MD 20748							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State 8/4/2000 Clinton, Maryland					
	21. Signature of Funeral Service Licensee George P. Kalas		22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. Atherosclerotic Cardiovascular Disease</td> <td rowspan="4">Approximate Interval Between Onset and Death YEARS</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Atherosclerotic Cardiovascular Disease	Approximate Interval Between Onset and Death YEARS	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Atherosclerotic Cardiovascular Disease	Approximate Interval Between Onset and Death YEARS								
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M						
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier George C. Hawjar, Jr.		29c. License number 039550		29d. Date signed (Month, Day, Year) 7-30-00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George C. Hawjar, Jr. M.D. 4850 Forbes Blvd Lanham, Md 20706										
State Registrar	31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature Beverly B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26092

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilford Harrison		2. Date of Death Month 07 Day 26 Year 2000		3. Time of Death 8:00 pm
	4a. Facility Name (If not institution, give street and number) Heartland Health Care Center-Adelphi		4b. City, Town, or Location of Death Adelphi		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 579-01-0552	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 7, 1910		9. Birthplace (State or Foreign Country) Wash., DC		
To Be Completed by Funeral Director	10a. State DC		10b. County None		10c. City, Town or Location Washington
	10d. Inside City Limits XX Yes 2 No				
	10e. Street and Number 1200 Delaware Ave., SE #227		10f. Zip Code 20024		10g. Citizen of What Country? United States
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) Collega		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Clerk		16b. Kind of Business/Industry Government
	17. Father's Name (First, Middle, Last) Wilford Harrison		18. Mother's Name (First, Middle, Maiden Surname) Georgiana Smith		
	19a. Informant's Name/Relationship (Type, Print) Granddaughter Frances Luckett-Butler		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Wetherborne Ct., Mitchellville, Md.		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial		20c. Location - City or Town, State 7-29-2000 Suitland, Md.
	21. Signature of Funeral Service Licensee Ralph E. Williams 767		22. Name and Address of Facility Ralph Williams Funeral Service 517 11th St., SE, Wash., DC 20003		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction Due to (or as a consequence of): Cardioarrrythima Due to (or as a consequence of): Prostate Carcinoma Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Prostate Carcinoma				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of causa of death? 1 Yes 2 No
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes 2 No
	28c. Injury at Work? 1 Yes 2 No		28d. Describe how Injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier [Signature]		29c. License number D42749		29d. Date signed (Month, Day, Year) July 28, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond O. Nwadiuko, Md.		9831 Greenbelt Rd Suite 101 Lanham, Md. 20706		
State Registrar	31. Date filed (Month, Day, Year) AUG 01 2000		3. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 26093

Amend # 31.PGC 8-1-2000 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel L. Herran				2. Date of Death Month Day Year July 28 2000		3. Time of Death 7:30AM	
	4a. Facility Name (If not Institution, give street and number) Bradford Oaks Nursing Home				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-32-8588	6. Sex 1 <input type="checkbox"/> M 3 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 22 1901		9. Birthplace (State or Foreign Country) Wash. DC.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Temple Hills			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4301 23rd Parkway #910			10f. Zip Code 20748		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Library of Congress			16b. Kind of Business/Industry Government		
	17. Father's Name (First, Middle, Last) Herbert Bongardner				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Unk.			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Raymond H. Herran Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 23rd Parkway #910 Temple Hills, Md. 20748				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 8-1-00 Suitland, Maryland		
	21. Signature of Funeral Service Licensee J. S. Sitt			22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, Maryland				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 109
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Michael S. Sitt			29c. License number 045365		29d. Date signed (Month, Day, Year) 7-31-00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Sitt 11701 Livingston Road # 101 Ft. Washington MD 20744-5100							
31. Date filed (Month, Day, Year) 7-31-2000				32. Registrar's Signature Barbara B. Sparks				

2005 10 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26094

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George A. Harrell				2. Date of Death Month Day Year July 25, 2000		3. Time of Death 8:25 PM	
	4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home				4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 577-07-4116		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 30, 1909	
	9. Birthplace (State or Foreign Country) Marshall, VA.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Oxon Hill	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 1324 Crisfield Drive		10f. Zip Code 20745	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: YY				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician				16b. Kind of Business/Industry Train Station			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Sounders Harrell				18. Mother's Name (First, Middle, Maiden Surname) Adelaid Fewell			
	19a. Informant's Name/Relationship (Type, Print) Charlotte A. Niess/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Suitland, MD.	
	21. Signature of Funeral Service Licensee George P. Kalas				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Cancer Due to (or as a consequence of): b. Prostate Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death More than 6 months Approx. 1 year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebro-vascular Accident COPD Atherosclerotic Cardio Vascular disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier George A. Harrell		29c. License number D 50653	
	29d. Date signed (Month, Day, Year) 7-26-2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRAN-C SURANA MD. 5851- Dealechurchton Road Deale. MD. 20751			
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUL 31 2000				32. Registrar's Signature B. Sparks			
	State Registrar				DHMH 16 Rev 6/95			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 26095

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN WILKEY HALL				2. Date of Death Month July Day 31 Year 2000		3. Time of Death 1:00pm		
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577 12 1591		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 3 10 1920		
	9. Birthplace (State or Foreign Country) Tennessee		10a. State Md		10b. County Montgomery		10c. City, Town or Location Spencerville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 15801 Phillips Oak Drive		10f. Zip Code 20868		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Federal Gov'n't		17. Father's Name (First, Middle, Last) Thomas Wilkey		18. Mother's Name (First, Middle, Maiden Surname) Ida Weems	
19a. Informant's Name/Relationship (Type, Print) Macy G. Hall Jr., Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10800 Riverwood Drive Potomac, Maryland 20854		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park Hyattsville, Maryland		20c. Location - City or Town, State 8/4/00	
21. Signature of Funeral Service Licensee <i>Ruth C. Hall</i>		22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 621 Florida Avenue, NW, Washington, DC 20001		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hypercarbic Respiratory Failure Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Bowel Perforation Due to (or as a consequence of): d. Sepsis		Approximate Interval Between Onset and Death 2 days 1 week 3 weeks 3 weeks			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D51908		29d. Date signed (Month, Day, Year) July 31 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dayle B. Magliaro MD 1811 Prince Phillip Drive Suite 327 Olney Maryland		31. Date filed (Month, Day, Year) AUG 2 2000		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26096

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Erwin HARRIMAN, Sr.						2. Date of Death Month Day Year July 29 2000		3. Time of Death 2314	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-28-2121		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 86 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) June 23, 1914		9. Birthplace (State or Foreign Country) Germany		10. Usual Residence of Decedent 10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11330 Greenberry Road		10f. Zip Code 21740		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) correctional counselor		16b. Kind of Business/Industry Dept. of Correction				
17. Father's Name (First, Middle, Last) Julius Harriman						18. Mother's Name (First, Middle, Maiden Surname) Anna Behrendt				
19a. Informant's Name/Relationship (Type, Print) Margaret L. Harriman - wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11330 Greenberry Road, Hagerstown, Md. 21740				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hebron Cemetery			Date 8-3-00		20c. Location - City or Town, State Winchester, Virginia		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Massive Pulmonary Embolus - Autopsy confirmed Due to (or as a consequence of):						Approximate Interval Between Onset and Death 4 hrs				
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dilated cardiomyopathy						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Sgt C Papuchas MD			29c. License number 032851			29d. Date signed (Month, Day, Year) 8/3/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Road Hagerstown MD 21742										
31. Date filed (Month, Day, Year) AUG 03 2000			32. Registrar's Signature Gene G Sparks							

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State of Maryland / Department of Health and Mental Hygiene

00 26097

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty May HOLDER				2. Date of Death Month Day Year July 30, 2000				3. Time of Death 9:32 a.m.						
	4a. Facility Name (If not institution, give street and number) 12016 Mapleville Road				4b. City, Town, or Location of Death Cavetown				4c. County of Death Washington						
Funeral Director	5. Social Security Number 218-24-8887		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 70		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) July 8, 1930		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Cavetown						
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 12016 Mapleville Road		10f. Zip Code 21720		10g. Citizen of What Country? USA								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) seamstress		16b. Kind of Business/Industry dress factory										
	17. Father's Name (First, Middle, Last) Richard Lawson Keller				18. Mother's Name (First, Middle, Maiden Surname) Isabelle unknown										
	19a. Informant's Name/Relationship (Type, Print) Christina Martin - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 84, 12024 Mapleville Rd., Cavetown, Md. 21720										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park		Date 8-2-00		20c. Location - City or Town, State Hagerstown, Maryland								
	21. Signature of Funeral Service Licensee Scott M. Minnick		22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740												
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>Adenocarcinoma with liver metastasis</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death 3 Mo.				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Mary E. Murray MD		29c. License number D23815		29d. Date signed (Month, Day, Year) 7/31/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. MURRAY 354 MILL ST. HAGERSTOWN MD 21740															
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature B. Sparks													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26098

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas M. Herbert						2. Date of Death Month Day Year Aug. 6 00		3. Time of Death 2:10pm	
	4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-26-2277		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) May 23, 1931		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 407 Guilford Ave.				10f. Zip Code 21740		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman			16b. Kind of Business/Industry Leather Processing			
17. Father's Name (First, Middle, Last) George Herman Herbert, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Gladys Elizabeth Thomas				
19a. Informant's Name/Relationship (Type, Print) Robin L. Slocum (daughter)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Glendale Dr. Salisbury, MD 21804				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Memorial Park August 9, 2000		20c. Location - City or Town, State Williamsport, MD 21795				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. MINS. Due to (or as a consequence of): b. Chronic obstructive AIRWAY DISEASE 10 years Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred N/A		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A				28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Manzanar J. SHAFI M.D.					29c. License number D28365		29d. Date signed (Month, Day, Year) 8.6.00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZAR J. SHAFI 1500 Pennsylvania Avenue Hagerstown, MD 21742										
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26099

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELVA LUCILLE HINES

2. Date of Death

August 3 2000

3. Time of Death

5 A.M.

4a. Facility Name (If not institution, give street and number)

19515 Meadowbrook Road

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral
Director

5. Social Security Number

220-10-3314

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 18, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington County

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19515 Meadowbrook Road

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Residence

17. Father's Name (First, Middle, Last)

John W. Stone

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Harbaugh

19e. Informant's Name/Relationship (Type, Print)

Richard D. Sheasley, Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Post Office Box 178, Blue Ridge Summit, PA 17214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery

Date

Aug. 9

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Flery Funeral Home

1331 Eastern Blvd. N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ARRHYTHMIA

Due to (or as a consequence of):

SECONDS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANOREXIA, DEPRESSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELA FOX

BRADFORD, MD

SUITE 130

1110 MEDICAL CAMPUS RD.

HAGERSTOWN, MD

31. Date filed (Month, Day, Year)

AUG 08 2000

32. Registrar's Signature

[Signature]

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26100

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA HODGES

2. Date of Death

07 26 2000

3. Time of Death

12:06 PM

4e. Facility Name (If not institution, give street and number)

HERITAGE HARBOUR HEALTH CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

167 01 3187

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/03/1911

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

VA

10b. County

Northumberland

10c. City, Town or Location

Heathesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

PO BOX 246

10f. Zip Code

22473-0246

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Ljubomir Zivkovic

18. Mother's Name (First, Middle, Maiden Surname)

Ljubica Trvojevich

19a. Informant's Name/Relationship (Type, Print)

Johanna Wilson/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 N Southwood Annapolis, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Monongahela Cemetery

Date

7/28/00

20c. Location - City or Town, State

North Braddock PA

21. Signature of Funeral Service Licensee

Melanie Wilhelm Wagner

22. Name and Address of Facility

Advent Funeral & Cremation Services
Annapolis MD 21401

23a. Part I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Advanced Dementia

Approximate Interval Between Onset and Death

Yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Tavaroh

29c. License number

041978

29d. Date signed (Month, Day, Year)

7-27-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Tavaroh PCH 1 Hosp N/ Cheryl M 20785

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

B. Jones

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ENCLOSURE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26101

amend item 23a per phys G786 8/17/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert Perlman Hoffman				2. Date of Death Month Day Year June 19, 2000				3. Time of Death 12:05 PM		
	4a. Facility Name (If not institution, give street and number) VA Maryland Health Care System				4b. City, Town, or Location of Death Perry Point				4c. County of Death Cecil		
Funeral Director	5. Social Security Number 219-14-0853		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 24, 1923		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 78 East Broadway				10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Six Years College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Never Employed				16b. Kind of Business/Industry Never Employed			
17. Father's Name (First, Middle, Last) Oscar Hoffman				18. Mother's Name (First, Middle, Maiden Surname) Augusta Perlman							
19a. Informant's Name/Relationship (Type, Print) Albert Hoffman (Brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12555 Oaks North Dr., San Diego, California 92128							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery		Date 6/23/00		20c. Location - City or Town, State Owings Mills, Maryland					
21. Signature of Funeral Service Licensee ► Thomas M. Patterson, Sr.				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): ASPIRATION PNEUMONIA										3 days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. CARDIOPULMONARY ARREST Due to (or as a consequence of): d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier ► [Signature]				29c. License number D21779				29d. Date signed (Month, Day, Year) June 19, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY NELLORE, M.D., VA Maryland Health Care System, Perry Point, MD 21902											
31. Date filed (Month, Day, Year) JUN 22 2000		32. Registrar's Signature [Signature]									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26102

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ina B. Hughes</i>				2. Date of Death Month <i>August</i> Day <i>3</i> Year <i>2000</i>				3. Time of Death <i>2:00 pm</i>		
	4a. Facility Name (If not institution, give street and number) <i>SunBridge Care & Rehabilitation</i>				4b. City, Town, or Location of Death <i>Elkton</i>				4c. County of Death <i>Cecil</i>		
Funeral Director	5. Social Security Number <i>214-34-2718</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>82</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <i>Aug. 15, 1917</i>		9. Birthplace (State or Foreign Country) <i>North Carolina</i>		10e. State <i>Maryland</i>		10b. County <i>Cecil</i>		10c. City, Town or Location <i>Rising Sun</i>		
Usual Residence of Decedent		10e. State		10b. County		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <i>432 Stevens Road</i>		10f. Zip Code <i>21911</i>		10g. Citizen of What Country? <i>USA</i>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i>College</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>Grover Cleveland Bell</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Eunice Blevins</i>				19a. Informant's Name/Relationship (Type, Print) <i>Ray A. Hughes/Son</i>			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>77 Fair Hill Drive Elkton, MD 21921</i>				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Harford Memorial Gardens</i>		20c. Location - City or Town, State <i>8-5-00 Havre de Grace, MD</i>			
21. Signature of Funeral Service Licensee <i>Richard L. Goodie</i>				22. Name and Address of Facility <i>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</i>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Metastatic Breast Cancer</i>			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <i>7/4/00</i>				28b. Time of Injury <i>M</i>			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <i>Slipped</i>				28e. Location (Street and Number or Rural Route Number, City or Town, State) <i>4078</i>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Misup Sim</i>				29c. License number <i>946412</i>			
29d. Date signed (Month, Day, Year) <i>8/4/00</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Misup Sim 279 S. Union Ave</i>				31. Date filed (Month, Day, Year) <i>AUG 04 2000</i>			
32. Registrar's Signature <i>James B. Sparks</i>				33. State Registrar <i>6</i>				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020			

ORIGINAL

ADH

DANIEL HOFFMAN

00-4518-025 amend item 8 per fh 6787 9/18/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26103

AMEND ITEMS: #23 PART I, 27 PER MEO 6787 9-6-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Justin Hoffman		2. Date of Death Month Day Year AUGUST 12, 2000		3. Time of Death 1415 PM
	4a. Facility Name (If not institution, give street and number) 1417 SEDUM SQUARE		4b. City, Town, or Location of Death BELCAMP		4c. County of Death HARFORD
Funeral Director	5. Social Security Number 528-61-6363	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Nov. 28, 1970		9. Birthplace (State or Foreign Country) New Jersey		
Usual Residence of Decedent					
10a. State MD		10b. County Harford		10c. City, Town or Location Belcamp	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1417 Sedum Square			10f. Zip Code 21017		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Electrical	
17. Father's Name (First, Middle, Last) Don Hoffman			18. Mother's Name (First, Middle, Maiden Surname) Joy Williams		
19a. Informant's Name/Relationship (Type, Print) Joy L. Prichard			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Sedum Square, Belcamp, Maryland 21017		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc.		20c. Location - City or Town, State West Chester, PA	
20d. Date 8/17/00					
21. Signature of Funeral Service Licensee <i>Kenneth B. Gorge</i>			22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		SEIZURE DISORDER			
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? Yes		24b. Were autopsy findings available prior to completion of cause of death? Yes			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE			
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Dennis Chutkan</i>		29c. License number OCME		29d. Date signed (Month, Day, Year) AUGUST 13, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chutkan 111 Penn Street, Baltimore, Maryland 21201					
31. Data filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature <i>Dennis B. Sparks</i>			

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

00-08-14 P06:13

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26104

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ISSAF

ISSA

2. Date of Death

7-28-2000

3. Time of Death

11:32pm

4a. Facility Name (If not institution, give street and number)

Casey House
6001 Muncaster Mill Rd.

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

219-80-5616

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5-25-45

9. Birthplace (State or Foreign Country)

Palestine

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1004 Houston Ave #1

10f. Zip Code

20912

10g. Citizen of What Country?

Usa

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Mohamed Issa

18. Mother's Name (First, Middle, Maiden Summa)

Warda Abdullah

19a. Informant's Name/Relationship (Type, Print)

Mohamed Darwish- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1004 Houston Ave #1, Takoma Park, Md. 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cem. 7-31-2000 Brentwood, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jane de Mota

22. Name and Address of Facility

UNIVERSAL II MORTUARY INC.
411 Kennedy St, N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GLIOBLASTOMA MULTIFOPME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

13mos

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mark S. Godec, M.D.

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

7-29-2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road
Mark S. Godec, M.D., Casey House, Rockville, Md. 20855State
Registrar

31. Date filed (Month, Day, Year)

JUL 31 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

00-4215-033
JERRY JOHNSON
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26105

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JERRY L. JOHNSON, JR.

2. Date of Death

Month Day Year
JULY 29, 2000

3. Time of Death

01:45 A.M.

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

215-98-0197

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

19 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 17, 1981

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12216 Wimbleton Street

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jerry Lee Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Monica E. Brooks

19a. Informant's Name/Relationship (Type, Print)

Monica Brooks Johnson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12216 Wimbleton Street, Upper Marlboro, MD 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Washington National Ceme.

Date

08/04
2000

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perenti

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident
3 ☐ Suicide 6 ☐ Could not be
determined
4 ☐ Homicide

28a. Date of Injury
(Month, Day, Year)

7-29-00

28b. Time of
Injury

0050 M

28c. Injury at
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Passenger auto collision

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

4405 Robert Lewis Ave

29e. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

David R. Fowler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 02 2000

32. Registrar's Signature

B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show
any injury or other traumatic event, the Medical Examiner must be notified at
800-555-8000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26106

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gloria Theresa Johnson

2. Date of Death

July 29 2000

3. Time of Death

0018

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-52-3379

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 13, 1928

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2657 Stanton Road, S.E. #108

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Childhood Development Aide

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charles Earl Butler

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Boykins

19a. Informant's Name/Relationship (Type, Print)

Cynthia P. Butler - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3604 Monte Carlo Pl., Forestville, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cem.

Date

8/3/2000

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador S. Synter, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

July 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Synter 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

AUG 01 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26107

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Alice Jernigan

2. Date of Death

Month Day Year
July 30, 2000

3. Time of Death

1116

4a. Facility Name (If not institution, give street and number)

9000 Briarcroft Lane #121

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-24-9058

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 1, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9000 Briar Croft Lane #121

10f. Zip Code

20798

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teller

16b. Kind of Business/Industry

Bank

17. Father's Name (First, Middle, Last)

George Dean

18. Mother's Name (First, Middle, Maiden Surname)

Mary unobtainable

19a. Informant's Name/Relationship (Type, Print)

James R. Rock / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 62nd Ave. Berwyn Heights, MD 20746

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Crematory August 1, 2000 Brentwood, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ft. Lincoln Funeral Home
3401 Bladensburg Rd. Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

H2055927

29d. Date signed (Month, Day, Year)

July 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Soto, 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26108

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MABLE S. JONES				2. Date of Death Month Day Year July 28, 2000		3. Time of Death 7:40pm	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 238-20-6452	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 16, 1914		9. Birthplace (State or Foreign Country) Bayboro, N.C.
	Usual Residence of Decedent							
10a. State		10b. County		10c. City, Town or Location Washington, D.C.			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1014 Lamont ST NW				10f. Zip Code 20010		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 year				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LPN			16b. Kind of Business/Industry Private Industry	
17. Father's Name (First, Middle, Last) Harvey Suggs				18. Mother's Name (First, Middle, Maiden Surname) Mary Best				
19a. Informant's Name/Relationship (Type, Print) Collie E. Jones / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Quail Trail Simpsonville, SC 29681				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY		Date 8/1/2000		20c. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST NW WDC 20011				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 days years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF ESRD						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 042878		29d. Date signed (Month, Day, Year) July 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablan MD 11119 Rockville Pike, Rockville, Maryland 20852								
State Registrar	31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature 					

ORIGINAL

00 26109

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26110

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl Roberta JONES				2. Date of Death Month 8 Day 4 Year 00		3. Time of Death 6:35 pm																		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington																		
Funeral Director	5. Social Security Number 214-34-1103		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 13, 1937																		
	9. Birthplace (State or Foreign Country) Maryland																								
Usual Residence of Decedent																									
10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
10e. Street and Number 12 South Conococheague Street				10f. Zip Code 21795		10g. Citizen of What Country? U.S.A.																			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry her own home																		
17. Father's Name (First, Middle, Last) Walter Lloyd Trumpower				18. Mother's Name (First, Middle, Maiden Surname) Mary Avis Stonesifer																					
19a. Informant's Name/Relationship (Type, Print) Mrs. Cheryl Vinson - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Post Office Box 302, Williamsport, Maryland 21795																					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date Aug. 9, 2000		20c. Location - City or Town, State Hagerstown, Maryland																	
21. Signature of Funeral Service Licensee Friedman				22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																									
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. INTRACEREBRAL BLEED</td> <td>Approximate Interval Between Onset and Death 24 hours</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. HYPERTENSION</td> <td>20 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. INSULIN Dependent - Diabetes</td> <td>10 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. INTRACEREBRAL BLEED	Approximate Interval Between Onset and Death 24 hours	Due to (or as a consequence of):		b. HYPERTENSION	20 years	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. INSULIN Dependent - Diabetes	10 years	Due to (or as a consequence of):		d.		
Immediate Cause (Final disease or condition resulting in death)	a. INTRACEREBRAL BLEED	Approximate Interval Between Onset and Death 24 hours																							
	Due to (or as a consequence of):																								
	b. HYPERTENSION	20 years																							
	Due to (or as a consequence of):																								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. INSULIN Dependent - Diabetes	10 years																							
	Due to (or as a consequence of):																								
d.																									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury N/A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred N/A																	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A		28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																									
29b. Signature and title of certifier Manjiv Ghay				29c. License number D28365		29d. Date signed (Month, Day, Year) 8-4-00																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZAR, J. SHARI 368 MILL ST. Hagerstown MD 21740.																									
31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature Sparks																							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26111

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD JOHNSON

2. Date of Death
Month Day Year

AUGUST 1 2000

3. Time of Death

10:30PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

218-26-5012

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JULY 5 1930

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

89 COLLEGE CREEK TERRACE

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1950-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

FISHERMAN

16b. Kind of Business/Industry

ANNAPOLIS CITY MARKET

17. Father's Name (First, Middle, Last)

BERNARD JOHNSON SR.

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE BROWN

19a. Informant's Name/Relationship (Type, Print)

VIVIAN LAMBERT (COUSIN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

905 H. ROYAL ST. ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN

Date

8/4/00

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

Larry D. Reese 1100483

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas Biondo, M.D.

29c. License number

D42800

29d. Date signed (Month, Day, Year)

8/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS BIONDO, M.D. VANHCS PERRY POINT, PERRY POINT MD 21902

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Handwritten signature and text: "Handwritten signature" and "0005 & 0 20A"

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26112

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE R. JOHNSON				2. Date of Death Month August Day 6 Year 2000		3. Time of Death 0555		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 222-18-8344		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Jan 26 1933		
	9. Birthplace (State or Foreign Country) New York		10a. State DE		10b. County Kent		10c. City, Town or Location Smyrna		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 25 Oak Dr.		10f. Zip Code 19977		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Clerk		16b. Kind of Business/Industry Department of Corrections					
17. Father's Name (First, Middle, Last) Edward Jerry Russell				18. Mother's Name (First, Middle, Maiden Surname) Florence Long					
19a. Informant's Name/Relationship (Type, Print) Clarence Johnson Jr. (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Oak Dr. Smyrna, DE. 19977					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kent Cremation		20c. Location - City or Town, State 8-7-00 Smyrna, DE.					
21. Signature of Funeral Service Licensee  M00510		22. Name and Address of Facility Faries Funeral Directors, Inc. 29 S. Main St. Smyrna, DE. 19977							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Respiratory Failure Due to (or as a consequence of):		b. Pneumonia Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Surgical Resident		29c. License number N8287		29d. Date signed (Month, Day, Year) August 6, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eric A. Peck 4940 Eastern Ave. Baltimore, MD. 21224									
31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26113

Amend # 26.Per Phys.PGC 8-4-2000 cr

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Juanita Kelly

2. Date of Death

Month Day Year
July 28, 2000

3. Time of Death

7:18 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

242-05-2540

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/25/23

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5408 Elmira Avenue

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse's Assistant

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Joseph Wright

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Spease

19a. Informant's Name/Relationship (Type, Print)

Clifton Spease/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5408 Elmira Ave., Lanham, Md. 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

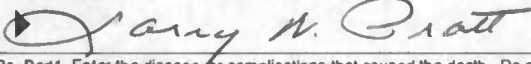
Forest Hills Mem. Gdns. 8/5/00

Date

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. ESRD-DD

Due to (or as a consequence of):

c. Hypoxic Encephalopathy

Due to (or as a consequence of):

d. Seizure Disorder

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ Other

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

Investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0046374

29d. Date signed (Month, Day, Year)

7/29/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony D. Thomas, M.D. 1328 Southern Ave., S.E. #312, Washington, D.C. 20032

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



100-100000

100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26114

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clifford Kobi		2. Date of Death Month August Day 1 Year 2000		3. Time of Death 3:30AM
	4a. Facility Name (If not institution, give street and number) 13816 Missouri Avenue		4b. City, Town, or Location of Death Brandywine		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 315-07-0479	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct. 3, 1921		9. Birthplace (State or Foreign Country) Indiana		
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Brandywine	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 13816 Missouri Avenue		10f. Zip Code 20613		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1943- If Yes, Give Year or Dates: 1967		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Career Air Force		16b. Kind of Business/Industry Military Ret.	
17. Father's Name (First, Middle, Last) Albert Kobi		18. Mother's Name (First, Middle, Maiden Surname) Unknown			
19a. Informant's Name/Relationship (Type, Print) Mike Kobi (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13816 Missouri Avenue Brandywine, Maryland 20613			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highland Memorial Gardens		20c. Location - City or Town, State Waterville Ohio	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735			
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. carcinoma of lung			Approximate Interval Between Onset and Death 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Due to (or as a consequence of):			
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CAD					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D46478	29d. Date signed (Month, Day, Year) 8-1-00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Patel 7501 Surratts Road #307, Clinton, Maryland 20735					
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26115

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACQUALYN D. KNOX

2. Date of Death

July 30, 2000

3. Time of Death

1645

Funeral
Director

4a. Facility Name (If not institution, give street and number)

11917 Crestwood Avenue

4b. City, Town, or Location of Death

Brandywine

4c. County of Death

Prince Georges

5. Social Security Number

577-62-1570

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEPT 15, 1947

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

BRANDYWINE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11917 CRESTWOOD AVE

10f. Zip Code

20613

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FLORAL DESIGNER

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

RICHARD WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

PEARL QUESENBERRY

19a. Informant's Name/Relationship (Type, Print)

DONALD KNOX / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11917 CRESTWOOD AVE, BRANDYWINE, MD 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLYWOOD CEMETERY

Date

8-3-00

20c. Location - City or Town, State

REMINGTON, VA

21. Signature of Funeral Service Licensee

Larry L. Simmons

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME

5538 MARLBORO PIKE, FORESTVILLE, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer with metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician:2 ☒ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Salvador Sylvestre, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

July 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvestre, 3001 Hospital Drive, Chevy Chase, Md. 20785

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

B. B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26116

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rita Margaret Kozik				2. Date of Death Month July Day 29 Year 2000		3. Time of Death 1:20 am	
	4a. Facility Name (If not institution, give street and number) Chesapeake Hospice House				4b. City, Town, or Location of Death Linthicum		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 577-09-4618		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 26, 1916	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Crownsville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2003 Martins Grant Court		10f. Zip Code 21032		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Government Printing Office				
17. Father's Name (First, Middle, Last) Herbert Landolt				18. Mother's Name (First, Middle, Maiden Surname) Sadie Baulieu				
19a. Informant's Name/Relationship (Type, Print) Daughter Margaret M. Patterson-Fielr				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2003 Martins Grant Court, Crownsville, MD 21032				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 8/1/00 Brentwood, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Metastatic Pancreatic Cancer					Approximate Interval Between Onset and Death 1 month	
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Chesapeake Hospice House						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 031551		29d. Date signed (Month, Day, Year) July 31, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell B. Delunzio 1600 S. Craig Highway Ste 602 Glen Burnie Md 21061								
31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature 						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26117

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY LORRAINE KLINE					2. Date of Death Month August Day 6 Year 2000		3. Time of Death 7:15 AM		
	4a. Facility Name (If not institution, give street and number) 19142 Olde Waterford Road					4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County		
Funeral Director	5. Social Security Number 214-42-0832		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Jan 23, 1944		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Washington County			10c. City, Town or Location Hagerstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 19142 Olde Waterford Road					10f. Zip Code 21742		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Residence		
17. Father's Name (First, Middle, Last) William Jeff Frederick					18. Mother's Name (First, Middle, Maiden Surname) Virginia M. Cook					
19a. Informant's Name/Relationship (Type, Print) Ronald E. Kline, Sr., Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19142 Olde Waterford Road, Hagerstown, Maryland 21742					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory			Date Aug. 7		20c. Location - City or Town, State Smithsburg, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Douglas A. Flery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cervical Cancer</u> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 5 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <i>Michael J. McCormack MD</i>		29c. License number 041667		29d. Date signed (Month, Day, Year) 8.7.00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael McCormack 1110 Medical Campus Rd. Hagerstown MD 21742										
31. Date filed (Month, Day, Year) AUG 08 2000			32. Registrar's Signature <i>[Signature]</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G786 8-18-00 WR.

Certificate of Death

Reg. No.

00 26118

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Garrett Keane				2. Date of Death Month Day Year AUGUST 07 2000		3. Time of Death 13:00 PM			
	4a. Facility Name (If not institution, give street and number) 2513 HOWARD GROVE ROAD				4b. City, Town, or Location of Death DAVIDSONVILLE		4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 220-82-3134		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) July 21, 1964		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland				10b. County Anne Arundel		10c. City, Town or Location Davidsonville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director		10e. Street and Number 2513 Howard Grove Road				10f. Zip Code 21035		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Yes, Give Year or Dates: 1984-87		13. Was Decedent of Hispanic Origin? (Specify Yes or No) I Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) yr.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner-Operator		16b. Kind of Business/Industry General Contractor				
		17. Father's Name (First, Middle, Last) Kenneth Nicholas Lodowski				18. Mother's Name (First, Middle, Maiden Surname) Paula Anne Keane				
		19a. Informant's Name/Relationship (Type, Print) Theresa A. Keane/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Howard Grove Road Davidsonville, MD 21035				
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens		20c. Location - City or Town, State 8-11-00 Davidsonville, MD				
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COCAINE INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death								
Physician /Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE						
		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 8-7-00		28b. Time of Injury Found: 12:55		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE		28f. Location (Street and Number or Rural Route Number, City or Town, State) RD. DAVIDSONVILLE, MARYLAND						
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 08, 2000		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201								
State Registrar		31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 26119

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Chaka Fitzroy Lessey				2. Date of Death Month Day Year JULY 31, 2000				3. Time of Death 12:46 A.M.				
	4a. Facility Name (If not institution, give street and number) 1239 SOUTHVIEW DRIVE				4b. City, Town, or Location of Death OXON HILL				4c. County of Death PRINCE GEORGE'S				
Funeral Director	5. Social Security Number 220 90 5765		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 22 Yrs.		8. Date of Birth (Month, Day, Year) April 1, 1978		9. Birthplace (State or Foreign Country) Washington D.C.				
	Usual Residence of Decedent 10a. State Maryland				10b. County Prince George's				10c. City, Town or Location Oxon Hill		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1209 Southview Drive #203				10f. Zip Code 20745				10g. Citizen of What Country? USA				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mover Technician				16b. Kind of Business/Industry Private				
	17. Father's Name (First, Middle, Last) Fitzroy Lessey				18. Mother's Name (First, Middle, Maiden Surname) Sylvia Dews								
	19a. Informant's Name/Relationship (Type, Print) Sylvia Dews/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Southview Drive #203 Oxon Hill, MD 20745								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem 8-4				20c. Location - City or Town, State Suitland, Maryland				
	21. Signature of Funeral Service Licensee <i>Kimberly Buscoe-Tonic</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Gunshot Wound of Head</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death		
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
											24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE								
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 7-31-00				28b. Time of Injury 0018 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot
Medical Certification: To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1239 Southview Dr Prince Georges Co, Md								
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 31, 2000
State Registrar	29b. Signature and title of certifier <i>Dennis Chutemo</i>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis Chutemo 111 Penn Street, Baltimore, Maryland 21201								
	31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature <i>[Signature]</i>								

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State of Maryland / Department of Health and Mental Hygiene 00 26120

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH S. LILLEY				2. Date of Death Month 8 Day 7 Year 2000		3. Time of Death 8:15 AM	
	4a. Facility Name (If not institution, give street and number) 8320 Hudson Drive				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 577-07-2787		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) January 5, 1912	
	9. Birthplace (State or Foreign Country) New York		10a. State MD		10b. County Charles		10c. City, Town or Location La Plata	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8320 Hudson Drive		10f. Zip Code 20646		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant		16b. Kind of Business/Industry Federal Govt.		17. Father's Name (First, Middle, Last) William H. Black	
	18. Mother's Name (First, Middle, Maiden Surname) Alda M. Ketcham		19a. Informant's Name/Relationship (Type, Print) Donald Lilley/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8320 Hudson Drive La Plata, MD 20646		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, MD.		21. Signature of Funeral Service Licensee David C. Ehr		22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A.	
	22. Name and Address of Facility P.O. BOX 567 LA PLATA, MD. 20646		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Endometrial Carcinoma		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24c. Describe how injury occurred	
	24d. Location (Street and Number or Rural Route Number, City or Town, State)		24e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		24f. Location (Street and Number or Rural Route Number, City or Town, State)		24g. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier B. LARRY JENKINS, M.D.		29c. License number D0033426	
	29d. Date signed (Month, Day, Year) 8-7-00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. LARRY JENKINS, M.D. 111 LAGRANGE AVE P.O. BOX 2665 LA PLATA, MD 20646		31. Date filed (Month, Day, Year) AUG 09 2000		32. Registrar's Signature Beverly G. Sparks	

ORIGINAL

00 26121

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26122

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HILDA LANKFORD				2. Date of Death Month Day Year July 26, 2000		3. Time of Death 5:00 am		
	4a. Facility Name (If not institution, give street and number) 513 Grandin Avenue				4b. City, Town, or Location of Death Severna Park		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 212-34-6387		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Apr 1, 1935		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 513 Grandin Avenue		10f. Zip Code 21146		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Gabriel Lukenich		18. Mother's Name (First, Middle, Maiden Surname) Minnie Lang	
19a. Informant's Name/Relationship (Type, Print) Thomas Lankford/ son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Grandin Avenue, Severna Park, MD 21146		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatic squamous carcinoma of skin Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 73 years.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number P12408		29d. Date signed (Month, Day, Year) 7/27/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT HADDAD 225 Greene Street Baltimore, MD, 21201		31. Date filed (Month, Day, Year) 7/27/ JUL 31 2000		32. Registrar's Signature <i>[Signature]</i>					

0005 1 8 JUN

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State of Maryland / Department of Health and Mental Hygiene

00 26123

amend item 10a,b, per fh G786 8/16/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph I. Lee				2. Date of Death Month Day Year July 5, 2000		3. Time of Death 4:20 pm	
	4a. Facility Name (If not institution, give street and number) 9603 Beachwood Avenue				4b. City, Town, or Location of Death Seabrook		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-18-6885	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10-06-22		9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
10a. State N/A		10b. County N/A		10c. City, Town or Location Washington, DC			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 221 Ingraham St.				10f. Zip Code 20011		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Employee			16b. Kind of Business/Industry Government	
17. Father's Name (First, Middle, Last) Joseph Lee				18. Mother's Name (First, Middle, Maiden Surname) Antoinette Blackistone				
19a. Informant's Name/Relationship (Type, Print) Ethel Lee -wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Ingraham Street, NW, Washington, D.C. 20011				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Date 7-17-00		20c. Location - City or Town, State Arlington, VA.		
21. Signature of Funeral Service Licensee Thomas D. Chapman				22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Avenue, NW, Wash. DC 20012				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Terminal Alzheimer's Due to (or as a consequence of): b. Anorexia Due to (or as a consequence of): c. Seizures Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Personal Care Home						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Susan Leggett-Johnson				29c. License number D38149		29d. Date signed (Month, Day, Year) 07/07/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Leggett-Johnson 6525 Belcrest Road, Hyattsville, MD. 20782								
State Registrar	31. Date filed (Month, Day, Year) JUL 11 2000		32. Registrar's Signature B. Sparks					

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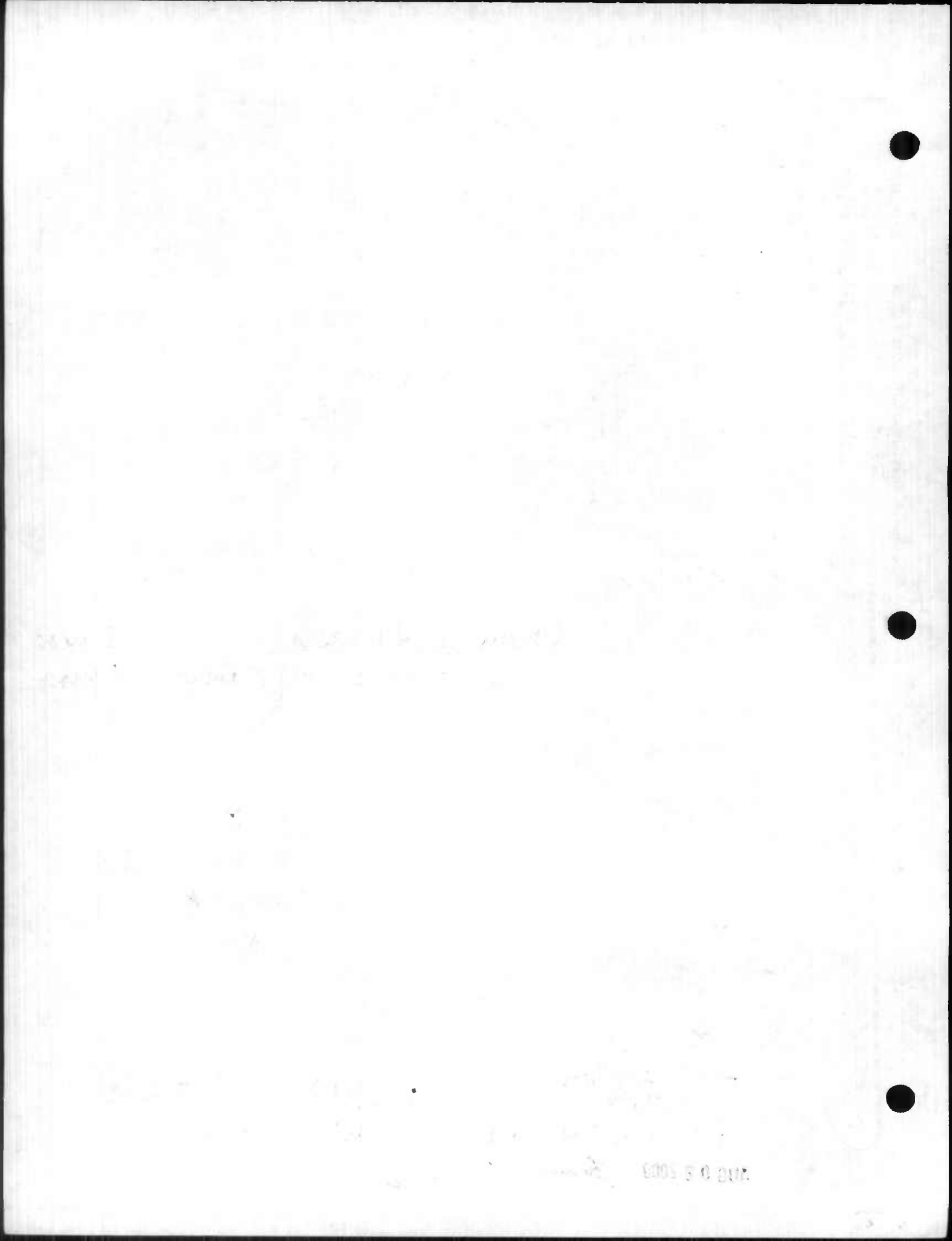
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eddie Lee McClendon				2. Date of Death Month Day Year July 29, 2000		3. Time of Death 12:30PM	
	4a. Facility Name (If not institution, give street and number) 1906 Bender Court				4b. City, Town, or Location of Death Landover		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 264-36-9811		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) May 12, 1932	
	9. Birthplace (State or Foreign Country) Dublin, GA		10a. State MD		10b. County Prince George's		10c. City, Town or Location Landover	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1906 Bender Court		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Frank McClendon				18. Mother's Name (First, Middle, Maiden Surname) Mamie Chris			
	19a. Informant's Name/Relationship (Type, Print) Dannie McClendon-wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Bender Court Landover MD 20785			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 8-5-00		20c. Location - City or Town, State Landover, MD	
	21. Signature of Funeral Service Licensee J.B. Jenkins		22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Brain metastases Due to (or as a consequence of): b. metastatic lung cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 2 mos 9 mos							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier D. J. Aidan						
		29c. License number D-17605		29d. Date signed (Month, Day, Year) 7/30/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. J. Aidan MD								
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature B. Jones						



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State of Maryland / Department of Health and Mental Hygiene

00 26125

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ozell Marie McCombs				2. Date of Death Month July Day 22 Year 2000				3. Time of Death 7:50 P.M.		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 242-38-7249		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth Month May Day 29 Year 1925		9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent 10a. State District of Columbia 10b. County Washington 10c. City, Town or Location Washington 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6304 - 5th Street, N. W.				10f. Zip Code 20011		10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Worker			16b. Kind of Business/Industry D.C. Government					
17. Father's Name (First, Middle, Last) Clauzell McCombs				18. Mother's Name (First, Middle, Maiden Surname) Margie Rawls							
19a. Informant's Name/Relationship (Type, Print) (daughter) Bonita M. West Brockenberry				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6304 - 5th Street, N.W.; Washington, D.C. 20011							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery				20c. Location - City or Town, State Adelphi, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility R.N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure 2nd to Massive Rt. Pulmonary Embolism Due to (or as a consequence of): b. ALZHEIMER'S DISEASE Due to (or as a consequence of): c. Hx of Hepatitis Due to (or as a consequence of): d. Hx of Metastatic CA of Uterus to Liver								Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D0053709			
				29d. Date signed (Month, Day, Year) 7/23/2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJ. K. CHAWLA 3060 Mitchellville rd Bowie MD 20716											
31. Date filed (Month, Day, Year) JUL 31 2000				32. Registrar's Signature 							

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State of Maryland / Department of Health and Mental Hygiene

00 26126

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Lena Brown McDonald				2. Date of Death Month Day Year July 25, 2000		3. Time of Death 6:24 P.M.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 237-26-1144	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 10, 1914		9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location College Park		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 4711 Berwyn House Road, Apt. 420				10f. Zip Code 20740		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Food Services			
	17. Father's Name (First, Middle, Last) James Brown				18. Mother's Name (First, Middle, Maiden Surname) Florence Covington			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) J. Calvin Adams (nephew)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5159 Thunder Hill Road, Columbia, Maryland 21045			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland		20d. Date July 29, 2000	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. END STAGE CHRONIC OBSTRUCTIVE Due to (or as a consequence of): c. LUNG DISEASE. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death FOUR WEEKS							
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and Title of Certifier 				29c. License number 822910		29d. Date signed (Month, Day, Year) July 25th / 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASIF S. QADRI, 4700 BERWYN HOUSE RD, COLLEGE PARK MD 20740							
31. Date filed (Month, Day, Year) JUL 31 2000				32. Registrar's Signature 				

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State of Maryland / Department of Health and Mental Hygiene

00 26127

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James E. Matthews				2. Date of Death Month Day Year July 12, 2000				3. Time of Death 1552 pm																																																																						
	4a. Facility Name (If not institution, give street and number) 4400 Shell Street				4b. City, Town, or Location of Death Capitol Heights				4c. County of Death Prince George's																																																																						
Funeral Director	5. Social Security Number 579-70-0617		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Jan. 18, 1953		9. Birthplace (State or Foreign Country) Washington, D.C.																																																																		
	Usual Residence of Decedent																																																																														
10a. State		10b. County		10c. City, Town or Location Washington, D.C.						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																					
10e. Street and Number 3739 D. Street, S.E. #101						10f. Zip Code 20019				10g. Citizen of What Country? United States																																																																					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black																																																																					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician				16b. Kind of Business/Industry Private																																																																					
17. Father's Name (First, Middle, Last) Walter Bowman						18. Mother's Name (First, Middle, Maiden Surname) Marie Matthews																																																																									
19a. Informant's Name/Relationship (Type, Print) Angelia T. Farmer/ Sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5717 Suitland Rd. Suitland, Md. 20746																																																																									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park				Date 8/4/00		20c. Location - City or Town, State Landover, Md.																																																																					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Alexander S. Pope Funeral Homes 20020 2617 Pennsylvania Ave. S.E. Washington, D.C.																																																																									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																															
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td colspan="12">GUNSHOT WOUNDS OF HEAD</td> </tr> <tr> <td colspan="13">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="12">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="12">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="12"></td> </tr> </table>														Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	GUNSHOT WOUNDS OF HEAD												Due to (or as a consequence of):													b.	Due to (or as a consequence of):												c.	Due to (or as a consequence of):												d.												
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	GUNSHOT WOUNDS OF HEAD																																																																													
	Due to (or as a consequence of):																																																																														
	b.	Due to (or as a consequence of):																																																																													
	c.	Due to (or as a consequence of):																																																																													
d.																																																																															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																																																															
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																																																															
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																																															
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene																																																																															
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 7/12/00 Found		28b. Time of Injury 1550 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT WAS SHOT																																																																					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) WOODED AREA						28f. Location (Street and Number or Rural Route Number, City or Town, State) 4400 SHELL ST CAPITOL HEIGHTS, MD																																																																									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																																																															
29b. Signature and title of certifier 						29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) July 13, 2000																																																																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201																																																																															
31. Date filed (Month, Day, Year) AUG 03 2000						32. Registrar's Signature 																																																																									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26128

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TREVELLA MAE MORELAND				2. Date of Death Month Day Year August 2 2000		3. Time of Death H A 0016 M		
	4e. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON		
Funeral Director	5. Social Security Number 236-40-8536	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/20/1929		9. Birthplace (State or Foreign Country) WEST VIRGINIA	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State WV	10b. County BERKELEY	10c. City, Town or Location MARTINSBURG			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 1124 1/2 WASHINGTON AVE.				10f. Zip Code 25401		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLY LINE		16b. Kind of Business/Industry CORNING GLASS				
	17. Father's Name (First, Middle, Last) GEORGE HOMER MORELAND				18. Mother's Name (First, Middle, Maiden Surname) HAZEL MAE DUGAN				
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) PAUL W. MORELAND / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 1434, INWOOD, WV 25428				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CENTRAL CHAPEL		Date 8/7/00		20c. Location - City or Town, State R.F.D. HEDGESVILLE, WV		
	21. Signature of Funeral Service Licensee Charles M. Brown				22. Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrest</u> Due to (or as a consequence of): b. <u>Atherosclerotic heart disease</u> Due to (or as a consequence of): c. <u>Chronic lung disease</u> Due to (or as a consequence of): d. <u>Staphylococcal pneumonia</u>								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Kevin C. Wackel, M.D.		29c. License number		29d. Date signed (Month, Day, Year) 8/4/00			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kevin C. Wackel, M.D. 11110 Medical Campus Dr. Hy. Md. 21742									
State Registrar	31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature Geneva B Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26129

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHRYN S. McCoy		2. Date of Death Month 08 Day 09 Year 00		3. Time of Death 11:55 AM	
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital		4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 235-42-7250		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.	
	8. Date of Birth (Month, Day, Year) 01-23-1926		9. Birthplace (State or Foreign Country) West Virginia			
Usual Residence of Decedent						
10a. State WV		10b. County Kanawha		10c. City, Town or Location Handley		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number P.O. Box 18			10f. Zip Code 25103		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator		16b. Kind of Business/Industry Restaurant	
17. Father's Name (First, Middle, Last) Lee Gabbard			18. Mother's Name (First, Middle, Maiden Surname) Mary Magdaline Huntsman			
19a. Informant's Name/Relationship (Type, Print) Mary Falbo/ daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Fayette Pike Montgomery, WV 25136			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kanawha Valley Memorial Gardens		20c. Location - City or Town, State 8-12-00 Glasgow, WV		
21. Signature of Funeral Service Licensee G. Scott Hinkle			22. Name and Address of Facility Hinkle Funeral Home P.O. Box 186 Davis, WV 26260			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Left Parietal Hemorrhagic CVA 2 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Alzheimers Dementia						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Paul Daniel Miller MD		29c. License number H 26154		29d. Date signed (Month, Day, Year) 8/9/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 wall Acres Drive Oakland Md 21550						
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature Benny S. Sparks				

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State of Maryland / Department of Health and Mental Hygiene

00 26130

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise Marie Myers						2. Date of Death Month Day Year August 4, 2000		3. Time of Death 01:15		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 232 82 5466		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 04 05 29		9. Birthplace (State or Foreign Country) Michigan		
	Usual Residence of Decedent										
10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 333 Mill Street				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk			16b. Kind of Business/Industry Retail				
17. Father's Name (First, Middle, Last) Luther Poindexter						18. Mother's Name (First, Middle, Maiden Surname) Dewey Manila Rodabush					
19a. Informant's Name/Relationship (Type, Print) Raleigh Myers - Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13621 Smithsburg Pike Smithsburg MD 21783					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rosedale Cemetery			20c. Location - City or Town, State 8700 Martinsburg WV					
21. Signature of Funeral Service Licensee Ben Borton						22. Name and Address of Facility Rosedale Funeral Chapel Martinsburg WV 25401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BILATERAL PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 2 weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBRAL VASCULAR DISEASE										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Dr. J. Delap...			29c. License number 00026523		29d. Date signed (Month, Day, Year) August 5, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. J. DELAPORTE MD 11115 MEDICAL CENTER ROAD HAGERSTOWN MD 21741											
31. Date filed (Month, Day, Year) AUG 17 2000			32. Registrar's Signature Benjamin Sparks								

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26131

Amended Item#23a per PHYG786 8/17/2000 EW

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Charles Earl Murray		2. Date of Death Month JUNE Day 12 Year 2000		3. Time of Death 16:35	
4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
5. Social Security Number 245-12-8691		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.	
8. Date of Birth (Month, Day, Year) Aug. 16, 1920		9. Birthplace (State or Foreign Country) North Carolina			
10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1014 Woodland Way		10f. Zip Code 21742	
10g. Citizen of What Country? U.S.A		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 42-45	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry School		17. Father's Name (First, Middle, Last) Orion Murray	
18. Mother's Name (First, Middle, Maiden Surname) Emma Whitman		19a. Informant's Name/Relationship (Type, Print) Lelia R. Murray (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Woodland Way Hagerstown, Md. 21742	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory June 13, 2000		20c. Location - City or Town, State Smithsburg, Md.	
21. Signature of Funeral Service Licensee Norris R. Davis		22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE METABOLIC ACIDOSIS Due to (or as a consequence of): Acute Renal Failure Due to (or as a consequence of): Uremia Days	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury of Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier Martin G. Baker, MD		29c. License number D0031880	
29d. Date signed (Month, Day, Year) 6/13/2000		29e. Name and address of person who completed cause of death (Item 28a) (Type, Print) ROBIN WOOD INT. MED. HAGERSTOWN		30. Registrar's Signature B. Sparks	
31. Date filed (Month, Day, Year) JUN 14 2000					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-635-1234.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Charles Earl Murray

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26132

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alan Marsh</i>				2. Date of Death Month <i>07</i> Day <i>31</i> Year <i>2000</i>				3. Time of Death <i>1:10 am</i>				
	4a. Facility Name (If not institution, give street and number) <i>101 Spotclub Road</i>				4b. City, Town, or Location of Death <i>Arnold</i>				4c. County of Death <i>Anne Arundel</i>				
Funeral Director	5. Social Security Number <i>118-40-1729</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>52</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Jul 26, 1948</i>		9. Birthplace (State or Foreign Country) <i>New York</i>				
	Usual Residence of Decedent				10a. State <i>MD</i>				10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Arnold</i>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <i>101 Spotclub Road</i>				10f. Zip Code <i>21012</i>		10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Risk Manager</i>				16b. Kind of Business/Industry <i>Lodging Company</i>					
17. Father's Name (First, Middle, Last) <i>Robert Bryant Marsh</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Catherine Zuromsky</i>									
19a. Informant's Name/Relationship (Type, Print) <i>Maureen H. Marsh/Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>101 Spotclub Road, Arnold, MD 21012</i>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lakemont Memorial</i>				20c. Location - City or Town, State <i>Davidsonville, MD</i>		20d. Date <i>Aug 4 2000</i>			
21. Signature of Funeral Service Licensed				22. Name and Address of Facility <i>Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</i>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pancreatic Cancer</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>10 months</i>													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D24532</i>		29d. Date signed (Month, Day, Year) <i>7/31/2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DAVID A VAN BUGHAN 27 South Greene St, Baltimore, MD 21201</i>													
31. Date filed (Month, Day, Year) <i>AUG 02 2000</i>				32. Registrar's Signature <i>[Signature]</i>									

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26133

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nelson George Malles				2. Date of Death Month Day Year Aug. 4, 2000		3. Time of Death 7:30 A.M.	
	4e. Facility Name (If not institution, give street and number) 3886 Norrisville Road				4b. City, Town, or Location of Death Jarrettsville		4c. County of Death Harford	
Funeral Director	5. Social Security Number 213-12-7965		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) 2/19/1909	
	Usual Residence of Decedent 10a. State Md. 10b. County Harford 10c. City, Town or Location Jarrettsville 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 3886 Norrisville Road		10f. Zip Code 21084	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) College				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Aircraft		
17. Father's Name (First, Middle, Last) William Henry Malles				18. Mother's Name (First, Middle, Maiden Surname) Mary A. Martin				
19a. Informant's Name/Relationship (Type, Print) Jerry Preston/ Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3889 Norrisville Rd. Jarrettsville, Md. 21084				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Jarrettsville Cem.		20c. Location - City or Town, State 8/7/00 Jarrettsville, Md.		
21. Signature of Funeral Service Licensee Benjamin W. Kurtz				22. Name and Address of Facility Jarrettsville, Md. 21084 E.G. Kurtz & Son, P.A. Funeral Home				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UROSEPSIS Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death Five days				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Mark W. Feld				
				29c. License number 135522		29d. Date signed (Month, Day, Year) August 4, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK W. FELD 2 NORTH AVENUE BEL AIR 21014								
31. Date filed (Month, Day, Year) AUG 4 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 26134

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES T. NEWMAN				2. Date of Death Month Day Year July 28 2000		3. Time of Death 06:43 P.M.	
	4a. Facility Name (If not institution, give street and number) 15211 Leeland Road				4b. City, Town, or Location of Death Bowie		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 217-36-7920	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	8. Date of Birth (Month, Day, Year) December 13, 1940	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Capitol Heights		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 6815 Drylog Street			10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer III		16b. Kind of Business/Industry WSSC (Retired)			
	17. Father's Name (First, Middle, Last) James H. Newman				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Butler			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Carrie R. Martin (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2576 Sussex Court Waldorf, Maryland 20602			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		Date 8-4-2000		20c. Location - City or Town, State Clinton, Maryland	
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 339 Hunt Place, N.E. Washington, D.C. 20019			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Shotgun Wound of Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7-28-00		28b. Time of Injury 1930 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Yard		28d. Describe how injury occurred subject shot			
					28f. Location (Street and Number or Rural Route Number, City or Town, State) 15211 Leeland Rd			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier [Signature]			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 30, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature [Signature]						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26135

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alex Eugene NAVE				2. Date of Death Month Day Year August 2, 2000				3. Time of Death 8:57 P.M.	
	4a. Facility Name (If not institution, give street and number) 14898 Bottom Road				4b. City, Town, or Location of Death Williamsport				4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-09-9256		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) April 22, 1911		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14898 Bottom Road		10f. Zip Code 21795		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Brick Manufacturer					
	17. Father's Name (First, Middle, Last) Alex Bradley Nave				18. Mother's Name (First, Middle, Maiden Surname) Ella Mae Teach					
	19a. Informant's Name/Relationship (Type, Print) M. Regina Mentzer/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1054 Arnoldstown Rd. Jefferson, MD 21755					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pinesburg Mennonite Cem.		20c. Location - City or Town, State Williamsport, Maryland		20d. Date 8-5-00			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe chronic obstructive Pulmonary Disease				Approximate Interval Between Onset and Death					
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 2000091		29d. Date signed (Month, Day, Year) 8-4-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER. LANDRIAN 282 Juma Cleveland, Piquette, MD 21786				31. Date filed (Month, Day, Year) AUG 04 2000				32. Registrar's Signature <i>[Signature]</i>		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26136

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Wilhelmena NOLL				2. Date of Death Month: AUGUST Day: 01 Year: 2000				3. Time of Death 0845	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington	
Funeral Director	5. Social Security Number 219-22-0514		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		If Under 1 Year Months: Days:		If Under 24 Hrs. Hours: Min.	
	8. Date of Birth (Month, Day, Year) Nov. 17 1927		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 33 Redwood Drive		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	
	16b. Kind of Business/Industry Financial Services Insurance		17. Father's Name (First, Middle, Last) Arnold Hettich		18. Mother's Name (First, Middle, Maiden Surname) Aline Grams		19a. Informant's Name/Relationship (Type, Print) Marianna Noll - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6311 Wind Rider Way Columbia, Md. 21045	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date 8/4/00		20c. Location - City or Town, State Hagerstown, Maryland		21. Signature of Funeral Service Licentiate <i>Scott M. Minich</i>	
	22. Name and Address of Facility Minnich Funeral Home		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Ovarian Cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 4 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael J. McCracken MD</i>	
	29c. License number 041667		29d. Date signed (Month, Day, Year) 8.2.00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. McCracken 11110 Medical Campus Rd. Hagerstown MD 21742		31. Date filed (Month, Day, Year) AUG 03 2000		32. Registrar's Signature <i>Sparks</i>	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26137

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris McGinnis Neall				2. Date of Death Month Day Year August 1 2000				3. Time of Death 6:50 AM	
	4a. Facility Name (If not institution, give street and number) 829 W. Central Ave.				4b. City, Town, or Location of Death Davidsonville				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 213-09-4565		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) May 20, 1915		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Davidsonville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 829 W. Central Ave.				10f. Zip Code 21035		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner			16b. Kind of Business/Industry General Store		
	17. Father's Name (First, Middle, Last) William Hill McGinnis				18. Mother's Name (First, Middle, Maiden Surname) Tabitha Tucker					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan N. Murnane / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3885 Green Meadow Lane Davidsonville, MD 21035					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All Hallows Chapel Cem.		20c. Location - City or Town, State Davidsonville, MD.					
	21. Signature of Funeral Service Licensee Brian Powell				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung cancer									
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier J. Selouch		29c. License number 019838		29d. Date signed (Month, Day, Year) 8/1/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selouch, M.D. 900 Bestgate Rd. Annapolis, Md. 21401										
31. Date filed (Month, Day, Year) AUG 03 2000		32. Registrar's Signature B. Spotts								

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

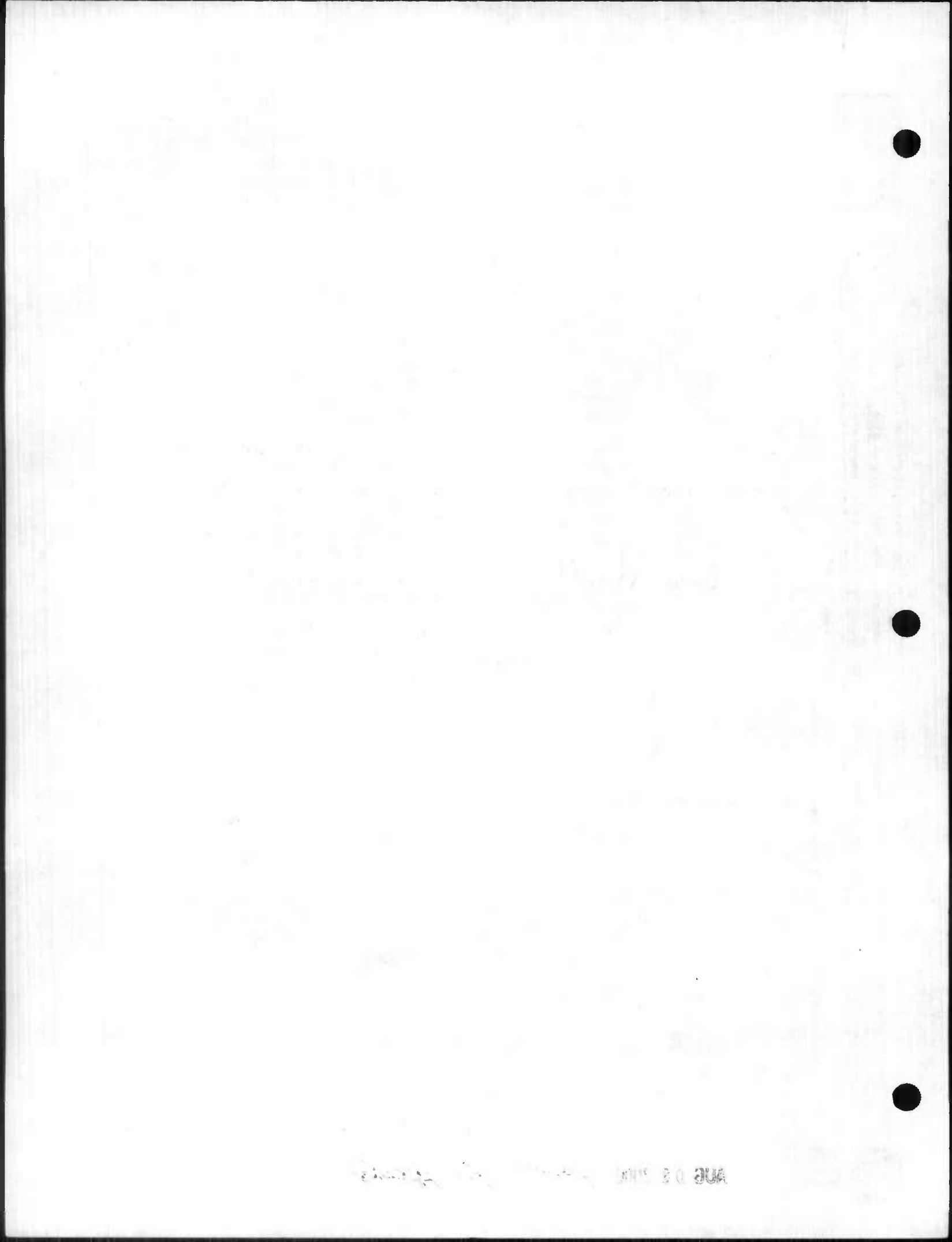
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26138

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Timothy U. Neimiller				2. Date of Death Month Day Year JULY 23, 2000		3. Time of Death 8:20 P.M.						
	4a. Facility Name (If not institution, give street and number) WOODLAND BEACH				4b. City, Town, or Location of Death EDGEWATER		4c. County of Death ANNE ARUNDEL						
Funeral Director	5. Social Security Number 214-88-4924	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 22, 1961		9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Severn			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 8104 Spalding Circle			10f. Zip Code 21144		10g. Citizen of What Country? USA							
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Heating & A/C								
	17. Father's Name (First, Middle, Last) Charles Roy Neimiller				18. Mother's Name (First, Middle, Maiden Surname) Esther Emily Wisner								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Esther E. Neimiller/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Spalding Circle Severn, MD. 21144								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem. Gardens		Date 7-27-00		20c. Location - City or Town, State Annapolis, MD.						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Drowning</u> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Drowning</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <u>Drowning</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death											
	b. _____ Due to (or as a consequence of):												
	c. _____ Due to (or as a consequence of):												
	d. _____ Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) scene											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Found 7-23-2000 unknown		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject drowned					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) near pier at Edgewater		28f. Location (Street and Number or Rural Route Number, City or Town, State) Anne Arundel County, Maryland											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 24, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201													
31. Date filed (Month, Day, Year) JUL 31 2000		32. Registrar's Signature 											

ORIGINAL

0005 1 E JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26139

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Phillips				2. Date of Death Month July Day 29 Year 2000				3. Time of Death 10:35 AM			
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 577-16-6995		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.			
	8. Date of Birth (Month, Day, Year) December 14, 1912		9. Birthplace (State or Foreign Country) South Carolina		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4500 Dix Street, N. E.		10f. Zip Code 20019		10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker			
	16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) Mack Phillips		18. Mother's Name (First, Middle, Maiden Surname) Julia (unknown)		19a. Informant's Name/Relationship (Type, Print) Ervin Phillips, Sr. (son) & Viola Smith Phillips (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4500 Dix Street, N.E.; Washington, D. C. 20019			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery/Aug. 3, 2000		20c. Location - City or Town, State Brentwood, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Brucapneumonia</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death days		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 			
	29c. License number D33357		29d. Date signed (Month, Day, Year) 7/29/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee Jonathan Musher 5530 Wisconsin Ave Chevy Chase Md		31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

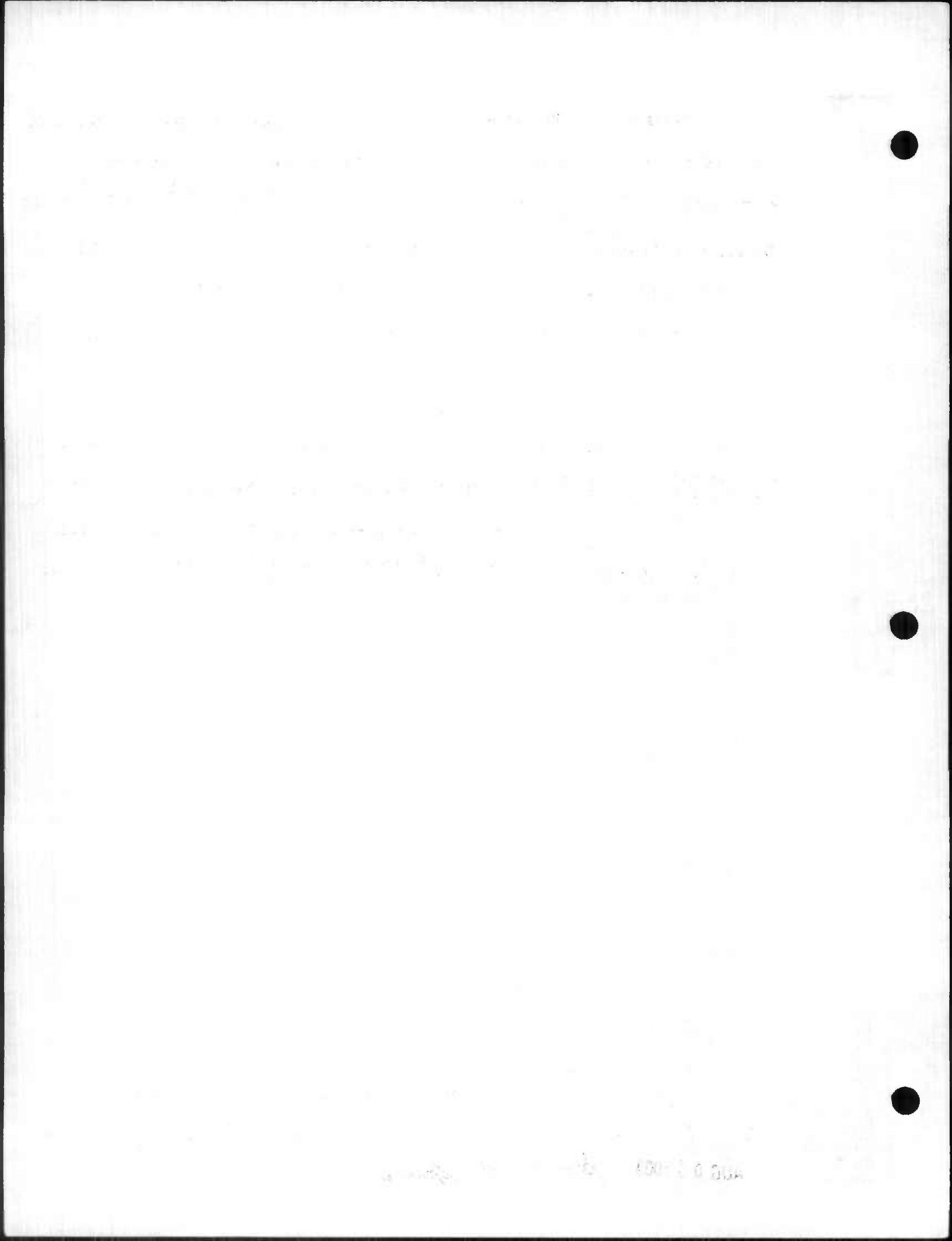
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b.& 20c.Per Family PGC 8-11-2000 cr **Certificate of Death**

Reg. No.

00 26140

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willie C. Pridgen

2. Date of Death

Month
JulyDay
28Year
2000

3. Time of Death

10:12PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-78-5778

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month
Oct.Day
23Year
1955

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3419 Dodge Park Road

10f. Zip Code

20785

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Willie C. Pridgen Sr.

18. Mother's Name (First, Middle, Maiden Summe)

Frances M. Pollard

19a. Informant's Name/Relationship (Type, Print)

Betty J. Dantzler - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

525 Wilson Bridge Dr., #C-1; Oxon Hill, MD 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Glenwood Cemetery
Forest Hill Memorial Gardens

Date

8/4/2000

20c. Location - City or Town, State

Wash., D.C.
Clinton, Maryland

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Severe hypertension

Due to (or as a consequence of):

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. acute respiratory failure

Due to (or as a consequence of):

day

c. acute endocarditis

Due to (or as a consequence of):

days

d. Recurrent peritonitis

month

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal insufficiency, Hypertension
by Hx, Anemia, Severe tricuspid
Regurgitation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Rustagi MD

29c. License number

D 24720

29d. Date signed (Month, Day, Year)

7-31-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. R. RUSTAGI
6632 Landover Road, Cheverly, MD 20785

31. Date filed (Month, Day, Year)

AUG 02 2000

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26141

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET TYLER PHELPS				2. Date of Death Month Day Year Aug. 1 2000		3. Time of Death 12:30 AM	
	4a. Facility Name (If not institution, give street and number) Villa Rosa Nursing Home				4b. City, Town, or Location of Death Mitchelville		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 215-44-3105		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) April 7, 1906	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	10e. State Maryland		10f. Zip Code 20719		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Post Office Worker		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Oden H. Dugan				18. Mother's Name (First, Middle, Maiden Surname) Lousina Watts			
	19e. Informant's Name/Relationship (Type, Print) Dorothy Cowan -Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 344, Bowie, MD 20719			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 8/4/00 Brentwood, MD			
	21. Signature of Funeral Service Licensee Claudette Bachman				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier William Y. [Signature]				29c. License number 320079		29d. Date signed (Month, Day, Year) 8/1/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Teblanowicz, no 2704 Executive Place, Jachuck, Mo 20706							
	31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26142

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ella Payne				2. Date of Death Month Day Year July 19, 2000				3. Time of Death 4:30PM		
	4a. Facility Name (If not institution, give street and number) Mariner Health Care				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 229-28-3686		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 3, 1905		9. Birthplace (State or Foreign Country) VIRGINIA		
	Usual Residence of Decedent				10c. City, Town or Location BETHESDA		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10a. State MARYLAND		10b. County MONTGOMERY		10e. Street and Number 5721 GROSVNER LANE				10f. Zip Code 20814		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE				16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) AURTHUR MAIDEN				18. Mother's Name (First, Middle, Maiden Surname) SARAH HALL							
19a. Informant's Name/Relationship (Type, Print) PATRICIA ANN JONES/ GRANDDAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Banning Place Hyattsville, MD 20783							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CEM. GALILEE BAPTIST CHURCH				Date 7-24-00		20c. Location - City or Town, State MONTROSS, VA	
21. Signature of Funeral Service Location <i>Kimberly Bruce Town</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MD 20746							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Deep Venous Thrombosis										Approximate Interval Between Onset and Death weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Venous Thrombosis										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Joel Schulman</i>				29c. License number D20516				29d. Date signed (Month, Day, Year) July 26, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joel Schulman, M.D. 9410 OLD GEORGETOWN RD. BETHESDA, MD 20814											
31. Date filed (Month, Day, Year) AUG 01 2000				32. Registrar's Signature <i>B. Spade</i>							

ORIGINAL

Handwritten scribbles and marks at the bottom left of the page.

000010000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26143

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JON T. PHILLIPS				2. Date of Death Month AUGUST Day 4 Year 2000		3. Time of Death 1000	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 217-44-7049	6. Sex M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-21-45	9. Birthplace (State or Foreign Country) MD.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County WORCESTER	10c. City, Town or Location OCEAN CITY			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 12041 OCEAN GATEWAY			10f. Zip Code 21842		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ARTISAN		16b. Kind of Business/Industry WOODWORKING			
17. Father's Name (First, Middle, Last) EMERSON CECIL PHILLIPS				18. Mother's Name (First, Middle, Maiden Surname) MARY W. YATES				
19a. Informant's Name/Relationship (Type, Print) JAMES PHILLIPS BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1675 DALRYMPLE RD. SUNDERLAND, MD. 20689				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK 8-8		20c. Location - City or Town, State BERLIN, MD.		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD.				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION						FEW MINS	
	Due to (or as a consequence of): CAD						FEW YRS	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 06241		29d. Date signed (Month, Day, Year) 08-05-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOLZWORTH M.D. 283 SNOW ST. SNOW HILL, MD. 21763								
State Registrar	31. Date filed (Month, Day, Year) AUG 06 2000		32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26144

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Elizabeth Peebles					2. Date of Death Month August Day 4 Year 2000		3. Time of Death 5:20 PM			
	4a. Facility Name (If not institution, give street and number) Reeders Memorial Home					4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington			
Funeral Director	5. Social Security Number 458-14-3534		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 10, 1922		9. Birthplace (State or Foreign Country) Texas		
	Usual Residence of Decedent										
10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 268 S. Potomac St.				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Aeronautics				
17. Father's Name (First, Middle, Last) Robert Hickman					18. Mother's Name (First, Middle, Maiden Surname) Anna Margarete Krebs						
19a. Informant's Name/Relationship (Type, Print) Vicki S. Durso (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Manilla St. Greenville, Miss. 38701						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date Aug. 5, 2000		20c. Location - City or Town, State Smithsburg, Md.				
21. Signature of Funeral Service Licensee Pennis L. Davis					22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 6 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated											
29b. Signature and title of certifier Dr. Robert Guedenet, MD					29c. License number D32518		29d. Date signed (Month, Day, Year) 8.5.00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/ 301-432-2222											
State Registrar		31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature Benita Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26145

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Audrey May Reed</i>				2. Date of Death Month <i>07</i> Day <i>27</i> Year <i>2000</i>		3. Time of Death <i>5:22 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Fort Washington Hospital</i>				4b. City, Town, or Location of Death <i>Fort Washington, MD</i>		4c. County of Death <i>PG</i>	
Funeral Director	5. Social Security Number <i>224-36-6016</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>70</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Nov. 12, 1929</i>	9. Birthplace (State or Foreign Country) <i>Radford, VA</i>
	Usual Residence of Decedent		10a. State <i>Maryland</i>		10b. County <i>Prince George's</i>		10c. City, Town or Location <i>Oxon Hill</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>1124 Kennebec Street, Apt. # 3</i>		10f. Zip Code <i>20745</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i>		College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cook</i>		16b. Kind of Business/Industry <i>Private Duty</i>		
17. Father's Name (First, Middle, Last) <i>William Reed</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Hattie Palmer</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Oscar R. W. Lee - Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6428 North Capitol Street NW Washington DC 20012</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metropolitan Crematory</i>		Date <i>8-7-00</i>		20c. Location - City or Town, State <i>Alexandria, VA</i>		
21. Signature of Funeral Service Licensee <i>Julia P. Marshall</i>				22. Name and Address of Facility <i>Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. <i>Hypertensive Cardiovascular Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Metastatic Breast Cancer, Liver Cancer</i> <i>Bone Cancer, Pneumonia</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dr. [Signature]</i>		29c. License number <i>D37066</i>		29d. Date signed (Month, Day, Year) <i>07-31-2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Uchechi T. Opaigboegwu, M.D.</i>				<i>4467 Old Branch Avenue #105 Temple Hills, MD 20748</i>				
31. Date filed (Month, Day, Year) <i>AUG 04 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1954

Troy Kenneth Richardson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, PER MEO G786 ^{8-23-00 WB} ~~Certificate of Death~~

Reg. No.

00 26146

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TROY KENNETH RICHARDSON				2. Date of Death Month Day Year July 28 2000				3. Time of Death 09:27 A.M.	
	4a. Facility Name (If not institution, give street and number) Rear of 135 Crescent Road				4b. City, Town, or Location of Death Greenbelt				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-02-4405		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 22 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Oct. 30, 1977		9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Lanham	
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 7214 Patterson Street		10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trainee		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Kenneth S. Richardson		18. Mother's Name (First, Middle, Maiden Surname) Betty Finley		19a. Informant's Name/Relationship (Type, Print) Kenneth S. Richardson/Father		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7214 Patterson Street, Lanham, Maryland 20706		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Walnut Grove Church Ceme.		20c. Location - City or Town, State Warrenton, N.C.		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GUNSHOT WOUND TO HEAD Contact Gunshot Wound of chest		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene		27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) 7-29-00		28b. Time of Injury 0849 M		
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred subject shot self		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Van - parking lot		28f. Location (Street and Number or Rural Route Number, City or Town, State) 135 Crescent Rd		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 29, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) AUG 02 2000		
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

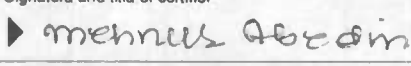
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26147

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JADA ANN ROSALES				2. Date of Death Month Day Year JULY 23 2000				3. Time of Death 3:31 PM		
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number N/A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 9		8. Date of Birth (Month, Day, Year) JULY 13 2000		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MD		10b. County PRINCE GEORGE'S		10c. City, Town or Location NEW CARROLLTON				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10a. Street and Number 6130 85th Avenue				10f. Zip Code 20784				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A				16b. Kind of Business/Industry N/A			
17. Father's Name (First, Middle, Last) Roger Rosales					18. Mother's Name (First, Middle, Maiden Surname) Arlene Reid						
19a. Informant's Name/Relationship (Type, Print) Arlene Washington-Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6130 85th Place New Carrollton MD 20784						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven			Date 7-29-00		20c. Location - City or Town, State Wheaton, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. HYPOXIC-ISCHEMIC ENCEPHALOPATHY Due to (or as a consequence of): b. RESPIRATORY FAILURE SECONDARY TO ABOVE Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29b. Signature and title of certifier 					29c. License number D28189			29d. Date signed (Month, Day, Year) 7/28/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEHNUZ ABEDIN, MD- 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785											
31. Date filed (Month, Day, Year) AUG 02 2000			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26148

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHNNIE REED

2. Date of Death

July 26 2000

3. Time of Death

01:58

4a. Facility Name (If not institution, give street and number)

VA MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

239-18-3772

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 4, 1920

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1007 4th Street S.E.

10f. Zip Code

20003

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1943-51

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Private Duty

17. Father's Name (First, Middle, Last)

Emose Reed

18. Mother's Name (First, Middle, Maiden Surname)

Rosie Taylor

19a. Informant's Name/Relationship (Type, Print)

Dorothy Reed - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1007 4th Street S.E. Washington DC 20003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico National Cem

Date

8-1-00

20c. Location - City or Town, State

Triangle, VA

21. Signature of Funeral Service Licensee

Julia P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington, D.C. 20011

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Supriya Goyal MD

29c. License number

AU 4176435G 13h3

29d. Date signed (Month, Day, Year)

July 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supriya Goyal

410 W. Lombard St., Apt 310 Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JUL 31 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26149

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD W. RIFENBERG				2. Date of Death Month August Day 5 Year 2000		3. Time of Death 0820	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 094-20-3769		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 6-14-26	
	9. Birthplace (State or Foreign Country) NY		10a. State NY		10b. County ALBANY		10c. City, Town or Location COHOES	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 37 JAMES STREET		10f. Zip Code 12047		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRINT SETTER		16b. Kind of Business/Industry PRINTING			
	17. Father's Name (First, Middle, Last) HAROLD E. RIFENBERG				18. Mother's Name (First, Middle, Maiden Surname) VIOLA HINES			
	19a. Informant's Name/Relationship (Type, Print) HELEN RIFENBERG				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 JAMES ST., COHOES, NY, 12047			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEMORY GARDEN		Date 8-9		20c. Location - City or Town, State COLONIE, NY	
	21. Signature of Funeral Service Licensee <i>John D. Ullrich</i>				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD, 21811			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death SEVERAL YRS							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dorothy C. Holzworth, M.D.</i>		29c. License number D 06241		29d. Date signed (Month, Day, Year) 08-06-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOLZWORTH, M.D., 203 SNOW ST, SNOW HILL, MD, 21865								
31. Date filed (Month, Day, Year) AUG 06 2000		32. Registrar's Signature <i>Geneva B. Sparks</i>						

ORIGINAL

Rifenberg, Edward W.
 DOB - 6/14/26 deceased 8/5/00
 094203769
 Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5+1

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26150

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEWEL PIRSTON RAY				2. Date of Death Month August Day 3 Year 2000		3. Time of Death 0850	
	4a. Facility Name (If not institution, give street and number) UNION HOSPITAL				4b. City, Town, or Location of Death ELKTON		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 212-38-8232	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 4, 1915		9. Birthplace (State or Foreign Country) ALABAMA
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County CECIL		10c. City, Town or Location ELKTON		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 65 CARDINAL				10f. Zip Code 21921		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired U.S. NAVY		16b. Kind of Business/Industry MEDICAL CORP.		
17. Father's Name (First, Middle, Last) NO INFORMATION				18. Mother's Name (First, Middle, Maiden Surname) ALICE RAY				
19a. Informant's Name/Relationship (Type, Print) JUDITH EBERHARD-DAUGHTER #1 DEVON COURT ANNAPOLIS MD 214031651				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON NATIONAL		Date AUG 30, 2000		20c. Location - City or Town, State ARLINGTON VA.		
21. Signature of Funeral Service Licensee Edward McKinnon				22. Name and Address of Facility Gee Funeral Home 259 E. MAIN ST. ELKTON MD.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Acute Renal Failure					Approximate Interval Between Onset and Death 3 days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Sepsis					Days	
		c.						
		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Sachdev S. MD		29c. License number D23322		29d. Date signed (Month, Day, Year) 8.6.2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. SACHDEV MD, 118 North St Suite 3B, Elkton MD 21921.								
31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature B. Sparks						

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26151

amend item 26 per verbal response G786 8/17/00 yg Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Ellis Spence, Sr.				2. Date of Death Month July Day 4 Year 2000		3. Time of Death 6 AM	
	4a. Facility Name (If not institution, give street and number) Talbot Hospice House, 586 Cynwood				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 218-10-9675		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 20, 1916	
	9. Birthplace (State or Foreign Country) Md.		10a. State MD		10b. County Caroline		10c. City, Town or Location Denton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 116 Siesta Drive		10f. Zip Code 21629		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1941- If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 H.S. grad		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mason		16b. Kind of Business/Industry construction		17. Father's Name (First, Middle, Last) Edward Ellis Spence	
	18. Mother's Name (First, Middle, Maiden Surname) Mary Rebecca Baynard		19e. Informant's Name/Relationship (Type, Print) Helen M. Spence		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Siesta Drive, Denton, Md. 21629		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Eastern Shore Veteran's Cemetery		20c. Location - City or Town, State Hurlock, Md.		21. Signature of Funeral Service Licensor Randolph P. Moore		22. Name and Address of Facility Moore Funeral Home, P.A. 12 S. Second St., Denton, Md. 21629	
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORONARY ARTERY DISEASE Due to (or as a consequence of): LIVER CANCER Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death 20 YEARS 1 YEAR		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPER TENSION		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier [Signature]		29c. License number D0053815		29d. Date signed (Month, Day, Year) 07/05/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORAH M. PULIMOOD, 510 SOUTH 5TH AVENUE, DENTON, MD		
31. Date filed (Month, Day, Year) JUL - 7 2000		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26152

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE M. SEWARD				2. Date of Death Month Day Year July 30, 2000				3. Time of Death 4:00 AM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 226-80-3835		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 7, 1912		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent 10a. State Maryland				10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 11325 New Hampshire Ave				10f. Zip Code 20904		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry N/A				
17. Father's Name (First, Middle, Last) James A. Alston				18. Mother's Name (First, Middle, Maiden Surname) Sophia Broadnax						
19a. Informant's Name/Relationship (Type, Print) Mary L. Morefield - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11434 Stewart Lane #C-2, Silver Spring MD 20904						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State 8-4-00 Brentwood, MD				
21. Signature of Funeral Service Licensee Julia P. Marshall				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. MYOCARDIAL INFARCTION Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): d. CARDIOMYOPATHY				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPTICEMIA				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Victor Onyejiaka MD		29c. License number D46529		29d. Date signed (Month, Day, Year) July 30 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR ONYEJIKA 7325A HARVEY PARKWAY GREENBELT MARYLAND										
31. Date filed (Month, Day, Year) AUG 01 2000				32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

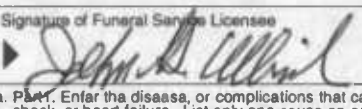
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26153

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LANCE R. SOWDER				2. Date of Death Month Day Year AUGUST 3 2000		3. Time of Death 1112	
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 213-36-6620	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	8. Date of Birth (Month, Day, Year) 9-22-38	9. Birthplace (State or Foreign Country) W. VA.			
	Usual Residence of Decedent				10a. State MD.		10b. County WORCESTER	
10c. City, Town or Location BERLIN				10d. Inmate City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 205 PITTS STREET				10f. Zip Code 21811		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER		15b. Kind of Business/Industry HYDRAULICS		
16. Decedent's Name (First, Middle, Last) IRA LEE SOWDER				17. Mother's Name (First, Middle, Maiden Surname) OLA MARIE WILLIAMS				
18. Informant's Name/Relationship (Type, Print) SANDRA BAILEY SISTER				19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 POPLAND ST. BALTIMORE, MD., 21226				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY 8-7		20c. Location - City or Town, State SALISBURY, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION 7-8 PM Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 								
29c. License number 020912								
29d. Date signed (Month, Day, Year) 8-3-00								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chodnicki, M.D. 400 EASTON AVE DR. SALISBURY, MD 21804								
31. Date filed (Month, Day, Year) AUG 06 2000								
32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26154

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jody Dale SPEARS				2. Date of Death Month Day Year July 30, 2000				3. Time of Death 1322		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington		
Funeral Director	5. Social Security Number 236-27-6318		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 19 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) Oct. 18, 1980		9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 18219 Woodside Drive		10f. Zip Code 21740		10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) technician	
16b. Kind of Business/Industry heating & air cond.		17. Father's Name (First, Middle, Last) Tom R. Spears, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Dawn Jones		19a. Informant's Name/Relationship (Type, Print) Dawn Morrison - mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18219 Woodside Dr., Hagerstown, Md. 21740			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		20c. Date 8-2-00		20d. Location - City or Town, State Hagerstown, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. gunshot wound to head Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 14 hrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. alcohol abuse depression		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) July 29, 2000		28b. Time of Injury 11:30 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred gunshot to head		28f. Location (Street and Number or Rural Route Number, City or Town, State) 18219 Woodside Dr. Hagerstown Maryland	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D01062		29d. Date signed (Month, Day, Year) August 1, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward W. Ditto, III, M. D., 19011 Orchard Terrace Rd., Hagerstown, Md. 21742			
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26155

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Elizabeth Smith				2. Date of Death Month Day Year August 4, 2000		3. Time of Death 8:25 AM	
	4a. Facility Name (If not institution, give street and number) Reeders Memorial Home				4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-20-9878		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 14, 1926	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Washington		10c. City, Town or Location Smithsburg	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13362 Greensburg Rd.		10f. Zip Code 21783		
10g. Citizen of What Country? U.S.A		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Grover C. Neikirk				18. Mother's Name (First, Middle, Maiden Surname) Ida E. Hollinger				
19a. Informant's Name/Relationship (Type, Print) Hazel J. Strite (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 School House Ct. Boonsboro, Md. 21713				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Long Meadow Church of the Brethren Cemetery		Date Aug. 7, 2000		20c. Location - City or Town, State Paramount, Md.		
21. Signature of Funeral Service Licensee Dennis L. Davis				22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 8 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. emphysema						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Robert Guedenet				29c. License number D32518		29d. Date signed (Month, Day, Year) 8/4/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/ 301-432-2222								
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature Sparks						

Handwritten signature or mark.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26156

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Oliver SCHAFER				2. Date of Death Month Day Year July 28 2000		3. Time of Death 04:30											
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington											
Funeral Director	5. Social Security Number 213-24-8143		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) April 4, 1932											
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown											
Usual Residence of Decedent																		
10a. Street and Number 125 Sunflower Drive			10f. Zip Code 21740			10g. Citizen of What Country? U.S.A.												
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:												
14. Race - American Indian, Black, White, etc. Specify: white			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) production clerk												
16b. Kind of Business/Industry truck manufacturer			17. Father's Name (First, Middle, Last) Edward NMN Schafer			18. Mother's Name (First, Middle, Maiden Surname) Helen Amelia Butts												
19a. Informant's Name/Relationship (Type, Print) Mrs Teresa C. Schafer - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Sunflower Drive, Hagerstown, Maryland 21740														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Memorial Park		20c. Location - City or Town, State Williamsport, Maryland		20d. Date July 31, 2000										
21. Signature of Funeral Service Licensee James L. Spies				22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ACUTE PULMONARY EDEMA</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>MASSIVE MYOCARDIAL INFARCTION</td> </tr> <tr> <td>c.</td> <td>CORONARY ARTERY DISEASE</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a.	ACUTE PULMONARY EDEMA	Approximate Interval Between Onset and Death	b.	MASSIVE MYOCARDIAL INFARCTION	c.	CORONARY ARTERY DISEASE	d.	
Immediate Cause (Final disease or condition resulting in death)	a.	ACUTE PULMONARY EDEMA	Approximate Interval Between Onset and Death															
	b.	MASSIVE MYOCARDIAL INFARCTION																
	c.	CORONARY ARTERY DISEASE																
	d.																	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, DIABETES MELLITUS, TYPE 1																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. Signature and title of certifier James L. Spies, Funeral Director																		
29c. License number D17067																		
29d. Date signed (Month, Day, Year) 7/29/00																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEVEN E. MERRITT, MD 107 NORTH AVE HAGERSTOWN, MD																		
31. Date filed (Month, Day, Year) AUG 02 2000			32. Registrar's Signature B. Sparks															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Edward Oliver Schaser

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26157

amend item 5 per fh G786 8/28/00 yf
amend item 8 per fh G787 9/26/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RONNIE David Sipes				2. Date of Death Month Day Year AUGUST 04, 2000		3. Time of Death 6:20 P.M.	
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 231-76-7716	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 51 11-18-53	9. Birthplace (State or Foreign Country) VA	
	Usual Residence of Decedent							
10a. State VA		10b. County Mecklenburg		10c. City, Town or Location Chase City		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 49 South Washington ST				10f. Zip Code 23924		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SURVEYOR		16b. Kind of Business/Industry SURVEYING		
17. Father's Name (First, Middle, Last) Richard Connie Sipes				18. Mother's Name (First, Middle, Maiden Surname) Jessie Lee Pottat				
19a. Informant's Name/Relationship (Type, Print) Tonya Horne, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13785 Hwy 47 Chase City, VA 23924				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodland Cemetery		Date 8-7-00		20c. Location - City or Town, State Chase City, VA		
21. Signature of Funeral Service Licensee Henry Davis				22. Name and Address of Facility P.O. Box 129 Newcomd Allgood Davis Fun. Home Chase City VA 23924				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 8-4-00		28b. Time of Injury 0609 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY		28d. Describe how injury occurred DRIVER OF PICK-UP IMPROPERLY KEY WEST SIGNS BURY, MONTGOMERY				
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Maureen Anne Yule		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 05, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANN D. KORONAK 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 17 2000		32. Registrar's Signature James A. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26158

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE SNYDER				2. Date of Death Month Day Year JULY 29, 2000				3. Time of Death 7AM	
	4a. Facility Name (If not institution, give street and number) GENESIS ELDERCARE SPA CREEK				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 259 34 2140		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 10, 1929		9. Birthplace (State or Foreign Country) GEORGIA	
	Usual Residence of Decedent				10a. State MARYLAND				10b. County ANNE ARUNDEL	
To Be Completed by Funeral Director	10c. City, Town or Location EDGEWATER				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 1662 BAY RIDGE ROAD				10f. Zip Code 21037				10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry HOME	
	17. Father's Name (First, Middle, Last) JOHN WILSON				18. Mother's Name (First, Middle, Maiden Surname) EFFIE SKINNER					
	19a. Informant's Name/Relationship (Type, Print) (HUSBAND) RICHARD CHARLES SNYDER SR.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1662 BAY RIDGE ROAD EDGEWATER, MD. 21037					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LAKEMONT CEMETERY		Date 08-02-00		20c. Location - City or Town, State DAVIDSONVILLE, MD.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LIVER CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number 041698		29d. Date signed (Month, Day, Year) JULY 31, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN C. HAMILTON, MD 205 RIVERWAY AVE ANNAPOLIS, MD 21401										
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26159

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John B. Shirley				2. Date of Death Month Day Year July 26, 2000		3. Time of Death 10:25 AM	
	4a. Facility Name (If not institution, give street and number) 1223 Van Buren Dr.				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 579-52-8446		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) August 14, 1914	
	9. Birthplace (State or Foreign Country) Missouri		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland				10b. County Anne Arundel		10c. City, Town or Location Annapolis	
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number 1223 Van Buren Dr.				10f. Zip Code 21403		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1931-1963		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Captain		16b. Kind of Business/Industry United States Navy	
	17. Father's Name (First, Middle, Last) George A. Shirley				18. Mother's Name (First, Middle, Maiden Surname) Louella M. Grant			
	19a. Informant's Name/Relationship (Type, Print) Evelyn Shirley/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 Van Buren Dr. Annapolis, MD 21403			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory		Date 7/31/00		20c. Location - City or Town, State Brentwood, MD	
	21. Signature of Funeral Service Licensee Todd E. Lillie				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Waldenstroms Macroglobulinemia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Jon L. Hopkins				29c. License number 0101051742		29d. Date signed (Month, Day, Year) July 28, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Jon Hopkins Bethesda Naval Hospital 8901 Wisconsin Ave. Bethesda, MD 20889								
31. Date filed (Month, Day, Year) JUL 31 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

0005 1 2 JUL

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Ann Spies				2. Date of Death Month AUGUST Day 03 , Year 2000		3. Time of Death 11:41 P.M.			
	4a. Facility Name (If not institution, give street and number) 29744 APPLE DRIVE				4b. City, Town, or Location of Death CORDOVA		4c. County of Death TALBOT			
Funeral Director	5. Social Security Number 215-62-0418		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 17, 1953	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Talbot		10c. City, Town or Location Cordova			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 29744 Apple Drive				10f. Zip Code 21655		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) insurance agent			16b. Kind of Business/Industry insurance			
17. Father's Name (First, Middle, Last) Hubert Lee Warren					18. Mother's Name (First, Middle, Maiden Surname) Jeanne Gardner					
19a. Informant's Name/Relationship (Type, Print) Charles Wayne Draper Jr/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Cedar Lane Greensboro, Maryland 21639						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery			20c. Location - City or Town, State Aug 7, 2000 Greensboro, Maryland				
21. Signature of Funeral Service Licensee <i>Stephen S. Radentz</i>				22. Name and Address of Facility Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639						
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. multiple gunshot wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) 8-3-2000		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was shot	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 29744 Apple drive Talbot County, Maryland			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 04, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) AUG - 7 2000			32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Cardinal eady
Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26161

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE BEATRICE WOODLAND THOMAS

2. Date of Death

Month Day Year
Aug. 6, 2000

3. Time of Death

6:56pm

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

213-34-0829

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 11, 1935

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

11808 OAK MANOR DRIVE

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

FRANK WOOD

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE WOODLAND WOOD

19a. Informant's Name/Relationship (Type, Print)

MARY
BERNICE GREENFIELD / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3432 WICHITA PLACE #E, GREENSBORO, NORTH CAROLINA 27405

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN CEM.

Date

8/11/00

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC HEART disease YES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CORONARY ARTERY DISEASE
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Ashvin Kumar J. Patel

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

Aug 07 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashvin Kumar J. Patel, M.D. 6 Industrial Park Dr. Waldorf, MD 20601

State
Registrar

31. Date filed (Month, Day, Year)

AUG 08 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Annie B. Thomas
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26162

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gloria Ann Turner				2. Date of Death Month Day Year August 2 2000				3. Time of Death 9:45PM	
	4a. Facility Name (If not Institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-32-0991		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) May 18, 1925		9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 9246 Three Oak Dr.		10f. Zip Code 20901		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. American Specify: Indian			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher - Administrator		16b. Kind of Business/Industry Government					
	17. Father's Name (First, Middle, Last) Orlando E. Hill				18. Mother's Name (First, Middle, Maiden Surname) Edna Evans					
	19a. Informant's Name/Relationship (Type, Print) Lawrence H. Turner - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9246 Three Oak Dr., Silver Spring, MD 20901					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 8/8/2000		20c. Location - City or Town, State Landover, MD			
	21. Signature of Funeral Service Licensee John T. Stewart, III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death Days Years			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Allen Oboler		29c. License number D0013456		29d. Date signed (Month, Day, Year) August 3, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Oboler - 8830 Cameron St., Suite 601, Silver Spring, MD 20910										
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature B. A. Smith								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26163

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Annette Tibbs				2. Date of Death Month Day Year AUGUST 01 2000				3. Time of Death 1:42 PM														
	4a. Facility Name (If not institution, give street and number) MALCOLM GROW MEDICAL CENTER				4b. City, Town, or Location of Death CAMP SPRINGS				4c. County of Death PRINCE GEORGE'S														
Funeral Director	5. Social Security Number 579-92-4310		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.														
	8. Date of Birth (Month, Day, Year) Mar. 25, 1961		9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights														
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1010 Addison Road				10f. Zip Code 20743		10g. Citizen of What Country? United States														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Account Tech				16b. Kind of Business/Industry Government														
	17. Father's Name (First, Middle, Last) Wilbert Hines				18. Mother's Name (First, Middle, Maiden Surname) Clara Thompson																		
	19a. Informant's Name/Relationship (Type, Print) Michael Tibbs - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Addison Rd., Capitol Heights, MD 20743																		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cramation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem.		Date 8/7/2000		20c. Location - City or Town, State Suitland, MD																
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ACUTE MYOCARDIAL INFARCTION</td> <td>UNKNOWN</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY DISEASE</td> <td>UNKNOWN</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	ACUTE MYOCARDIAL INFARCTION	UNKNOWN	b.	CORONARY ARTERY DISEASE	UNKNOWN	c.			d.		
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	ACUTE MYOCARDIAL INFARCTION	UNKNOWN																			
b.		CORONARY ARTERY DISEASE	UNKNOWN																				
c.																							
d.																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBESITY																							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																							
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																							
28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
29b. Signature and title of certifier  29c. License number GA 41380 29d. Date signed (Month, Day, Year) AUGUST 01 2000																							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAWN VARNEY, MAJ, USAF, MC 89 MDG / 1050 W PERIMETER RD ANDREWS AFB, MD 20762																							
31. Date filed (Month, Day, Year) AUG 04 2000 32. Registrar's Signature 																							

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
 Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26164

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Augustus Tongue				2. Date of Death Month Day Year JULY 25, 2000		3. Time of Death 07:30 A.M.	
	4a. Facility Name (If not institution, give street and number) ROUTE #50 and ROUTE # 97				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 215-30-5225		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) April 11, 1934	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Prince George's		10c. City, Town or Location Springdale	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3504 Edwards Street		10f. Zip Code 20774		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Eli Tongue	
	18. Mother's Name (First, Middle, Maiden Surname) Katherine Hopkins		19a. Informant's Name/Relationship (Type, Print) Matilda R. Tongue- Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Edwards Street Springdale MD 20774		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Chews Memorial Methodist		20c. Date 7-31-00		20d. Location - City or Town, State Owensville, MD		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. HEAD AND NECK INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 7/25/00		28b. Time of Injury 0720 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVER OF TRUCK WHICH STRUCK A DUMP TRUCK WHEN IT PULLED INTO HIS PATH RT. 50 AT RT. 97 ANNAPOLIS, MD	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 26, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPLE, MD. 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month/Day, Year) AUG 02 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26165

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kevin E. Thorne				2. Date of Death Month Day Year July 31, 2000		3. Time of Death 10:20 A.M.		
	4a. Facility Name (If not institution, give street and number) 10505 Cedarville Rd.				4b. City, Town, or Location of Death Brandywine		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 577-96-7763	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 17, 1961		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Brandywine		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 10505 Cedarville Rd., Box 411				10f. Zip Code 20613		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Plumbing			
17. Father's Name (First, Middle, Last) Alvin R. Thorne				18. Mother's Name (First, Middle, Maiden Surname) Jetta L. Vallalay					
19a. Informant's Name/Relationship (Type, Print) Jetta L. Thorne/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Oaklawn Rd., Ft. Washington, MD 20744					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 8/3/2000		20c. Location - City or Town, State Suitland, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Kidney Failure</u> Due to (or as a consequence of): b. <u>Diabetes + Hypertension</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D6050275		29d. Date signed (Month, Day, Year) 8/1/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric C. Greenberg, M.D. 11125 Rockville Pike #209, Rockville, MD									
31. Date filed (Month, Day, Year) AUG 01 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26166

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William H. Toles				2. Date of Death Month Day Year July 29, 2000		3. Time of Death 14:58	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-05-6234		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) July 20, 1919	
	9. Birthplace (State or Foreign Country) Madison, VA		10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 720 Taylor Street, N. W.		10f. Zip Code 20011		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African-American		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) twelve years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) B & O Railroad Supervisor		16b. Kind of Business/Industry Private				
17. Father's Name (First, Middle, Last) Lucien Toles				18. Mother's Name (First, Middle, Maiden Surname) Othelia E. Massey				
19a. Informant's Name/Relationship (Type, Print) Mary E. Robinson - Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 430 Ridge Rd., SE Washington, D.C. 20019 #201				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery		20c. Date 8/3/2000		20d. Location - City or Town, State Washington, D.C.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd., NE Washington, D.C. 20019				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Sepsis Due to (or as a consequence of): b. Endstage Renal disease Due to (or as a consequence of): c. Thrombocytopenia Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D0052999		29d. Date signed (Month, Day, Year) 7/30/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ali Rahimian 1328 Southern Ave. #200 Washington, D.C. 20032								
31. Date filed (Month, Day, Year) AUG 01 2000		Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26167

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SILAS P TOLLIVER				2. Date of Death Month AUGUST Day 6 Year 2000		3. Time of Death 10:39AM		
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 425-34-7421		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 26, 1929		
	9. Birthplace (State or Foreign Country) MISSISSIPPI		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1902 ROSEMARY HILL VILLAGE #3		10f. Zip Code 20910		10g. Citizen of What Country? UNITED STATES	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE		College (1-4 or 5+) SUPERVISOR SHIPPING DEPT.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT		16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) CURTIS TOLLIVER				18. Mother's Name (First, Middle, Maiden Surname) MARY GRAY TOLLIVER					
19a. Informant's Name/Relationship (Type, Print) NINA CHANDLER / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12015 GREEN TEA TURN, UPPER MARLBORO, MARYLAND 20772					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERAN CEM.		Date 8/10/00		20c. Location - City or Town, State CHELTENHAM, MARYLAND			
21. Signature of Funeral Service Licensee Lidia C. Thornton Johnson		22. Name and Address of Facility THORNTON FUNERAL HOME, P.A.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory failure Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Renal Failure Atrial Fibrillation		Approximate Interval Between Onset and Death 1 day 1 day			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. Anderson		29c. License number D051714		29d. Date signed (Month, Day, Year) August, 6, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JATINDER S. SEKHON		31. Date filed (Month, Day, Year) AUG 09 2000		32. Registrar's Signature Benita B. Sparks		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd. #102 Rockville, MD 20850			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26168

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLSWORTH DERUNDEL TUCKER				2. Date of Death Month Day Year JULY 31, 2000		3. Time of Death 5:45AM		
	4a. Facility Name (If not institution, give street and number) 820 ST. GEORGE BARBER ROAD				4b. City, Town, or Location of Death DAVIDSONVILLE		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 215 12 1882	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 23, 1919		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location DAVIDSONVILLE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 820 ST. GEORGE BARBER ROAD			10f. Zip Code 21035		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-43		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ROADS WORKER		16b. Kind of Business/Industry PUBLIC WORKS				
	17. Father's Name (First, Middle, Last) ERNEST D. TUCKER				18. Mother's Name (First, Middle, Maiden Surname) LILLY LEITCH				
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) BETTY P. TUCKER (WIFE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 ST. GEORGE BARBER ROAD DAVIDSONVILLE, MD. 21035					
	20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 08-04-00		20c. Location - City or Town, State ALEXANDRIA, VA.		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>Lung Cancer</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number 053306		29d. Date signed (Month, Day, Year) JULY 31, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CURTIS HARRIS MD 600 Ridge Ave Ste 231 Annapolis, MD 21401									
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26169

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence Michael Tyson				2. Date of Death Month Day Year July 30, 2000		3. Time of Death 1:37 AM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 230-50-5326	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	8. Under 1 Year Months Days	8. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 27, 1938		9. Birthplace (State or Foreign Country) Wash. D.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Riva		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 42 Shorewalk Road				10f. Zip Code 21140		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson		16b. Kind of Business/Industry Retail			
	17. Father's Name (First, Middle, Last) Elder A. Tyson				18. Mother's Name (First, Middle, Maiden Surname) Eloise K. Nyce			
	19a. Informant's Name/Relationship (Type, Print) Eloise Tyson/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Shorewalk Rd. Riva, MD 21140			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fairfax Mem. Park		20c. Date 8/2/00		20d. Location - City or Town, State Fairfax, VA	
	21. Signature of Funeral Service Licensee Todd Liller				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis MD			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non-small cell lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number 044804		29d. Date signed (Month, Day, Year) 7/31/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN M. DODGE MD, 8028 Ritchie Hwy Pasadena MD 21122								
31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26170

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Carol J. Torello</i>				2. Date of Death Month <i>July</i> Day <i>31</i> Year <i>2000</i>				3. Time of Death <i>3:20 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Calvert Manor Healthcare Center</i>				4b. City, Town, or Location of Death <i>Rising Sun</i>				4c. County of Death <i>Cecil</i>	
Funeral Director	5. Social Security Number <i>376-32-2323</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>65</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <i>Dec. 8, 1934</i>		9. Birthplace (State or Foreign Country) <i>Michigan</i>		10a. State <i>New York</i>		10b. County <i>Erie</i>		10c. City, Town or Location <i>Grand Island</i>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>1788 Bedell Road</i>		10f. Zip Code <i>14072</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own Home</i>		17. Father's Name (First, Middle, Last) <i>Wilbert Tomlinson</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Bertha McWha</i>		19a. Informant's Name/Relationship (Type, Print) <i>Sharon L. Wright</i>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1788 Bedell Rd., Grand Island NY 14072</i>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lakeside Cemetery</i>		20c. Location - City or Town, State <i>Port Huron, Michigan</i>		20d. Date <i>8-4-00</i>		
21. Signature of Funeral Service Licensee <i>Richard L. Goodie</i>		22. Name and Address of Facility <i>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>1. Congestive Heart Failure</i> Due to (or as a consequence of): <i>2. Atherosclerosis</i> Due to (or as a consequence of): <i>3. Multiple Sclerosis</i> Due to (or as a consequence of): <i>4. Seizure disorder</i>		Approximate Interval Between Onset and Death <i>2 days</i> <i>years</i> <i>life</i> <i>life</i>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Malcolm D. Phillips MD</i>		29c. License number <i>D09482</i>		29d. Date signed (Month, Day, Year) <i>7/31/00</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Malcolm D. Phillips, MD Masonic Building Darlington, MD 21034</i>		
31. Date filed (Month, Day, Year) <i>AUG 02 2000</i>		32. Registrar's Signature <i>Bertie G. Sparks</i>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26171

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howard William Tharp

2. Date of Death

Month Day Year
AUGUST 01, 2000

3. Time of Death

1:20 AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTHCARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral
Director

5. Social Security Number

216-18-9474

6. Sex

M 2 F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 16, 1911

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State
West Virginia

10b. County

Greenbrier

10c. City, Town or Location

Renick

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

U.S. Route 219

10f. Zip Code

24966

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Eight Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmhand

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Allen Tharp

18. Mother's Name (First, Middle, Maiden Surname)

Sabina Holmes

19a. Informant's Name/Relationship (Type, Print)

Emma Jean Walker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18709 Rolling Acres Way, Olney, Maryland 20832

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Morningside Cemetery

Date

8/3/00

20c. Location - City or Town, State

Renick, West Virginia

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Approximate Interval Between Onset and Death

UNKNOWN

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

UNKNOWN

Due to (or as a consequence of):

ATRIAL FIBRILLATION

UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20215

29d. Date signed (Month, Day, Year)

AUGUST 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARMACHANDRA NAIR, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD. 21902

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

B. Sparks

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26172

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren H. Tiley		2. Date of Death Month Day Year August 2 2000		3. Time of Death 1914
	4a. Facility Name (If not institution, give street and number) Union Hospital		4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil
Funeral Director	5. Social Security Number 293-09-9522	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) NOV 18, 1918		9. Birthplace (State or Foreign Country) Ohio		
Usual Residence of Decedent					
10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 55 Perch Creek Road			10f. Zip Code 21921		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941 to 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman/Delivery Driver		16b. Kind of Business/Industry Beverage Manufacturer/Distributor
17. Father's Name (First, Middle, Last) Edwin Louis Tiley			18. Mother's Name (First, Middle, Maiden Surname) Signa Borjvig		
19a. Informant's Name/Relationship (Type, Print) Irma Jeannie Chester/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Water Street, P.O. Box 143, Charlestown, Maryland 21914-0143		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Conception Cemetery		Date 8/4/00	20c. Location - City or Town, State Elkton, Maryland
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):			Approximate Interval Between Onset and Death 1 DAY
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. CORONARY ARTERY DISEASE Due to (or as a consequence of):			2 YEARS
		c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):			10 YEARS
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 00007463		29d. Date signed (Month, Day, Year) 8-3-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolando A. Najera, M.D., 111 W. High Street, Elkton, MD 21921					
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

00 26173

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26174

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence C. Uptegrove		2. Date of Death Month July Day 31 Year 2000		3. Time of Death 7:00AM
	4a. Facility Name (If not institution, give street and number) Malcolm Grow Medical Center AAFB		4b. City, Town, or Location of Death Camp Springs		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 577-48-7714	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In y.s. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) April 7, 1936		9. Birthplace (State or Foreign Country) New Jersey		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Forestville
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 2810 East Avenue		10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Kitchen Assistant		16b. Kind of Business/Industry Hospital
	17. Father's Name (First, Middle, Last) William D. Uptegrove		18. Mother's Name (First, Middle, Maiden Surname) Alberts R. Crisman		
	19a. Informant's Name/Relationship (Type, Print) Alberta C. Hitt (Mother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 East Avenue Forestville, Maryland 20747		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Ridge Cemetery		20c. Location - City or Town, State Blairstown, New Jersey
	21. Signature of Funeral Service Licensee Charles L. Belinger		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic obstructive Pulmonary disease				Approximate Interval Between Onset and Death 3 years
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number D46478		29d. Date signed (Month, Day, Year) 7.31.00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh A. Patel, 7501 Sunnyside Rd #1307, Clinton, MD 20735					
State Registrar	31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature [Signature]		

ORIGINAL


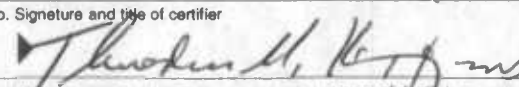
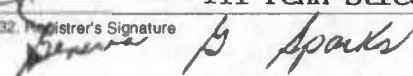
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26175

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Dale VanGosen, Sr.		2. Date of Death Month Day Year AUGUST 02, 2000		3. Time of Death 08:30 A.M.
	4a. Facility Name (If not institution, give street and number) 6820 GERMAN HILL ROAD		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 236 46 1497	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 11, 1933		9. Birthplace (State or Foreign Country) West Virginia		
Usual Residence of Decedent					
10a. State WV		10b. County Morgan		10c. City, Town or Location Berkeley Springs	
10e. Street and Number 906 Berry Street		10f. Zip Code 25411		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: War Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaper	
16b. Kind of Business/Industry Landscaping		17. Father's Name (First, Middle, Last) Berkeley Carter VanGosen		18. Mother's Name (First, Middle, Maiden Surname) Martha Ellen Barney	
19a. Informant's Name/Relationship (Type, Print) Richard D. VanGosen, Jr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 Glenwood Drive, Glendale, KY 42740			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenway Cemetery		20c. Location - City or Town, State Berkeley Springs, WV	
21. Signature of Funeral Service Licensee  M00522		22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. 306 Union St., Berkeley Springs, WV 25411-1837			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Myocardial Infarction Complicated with Hemiparesis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 03, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEONNE McKnight 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26176

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Peggy J. Williams				2. Date of Death Month: August, Day: 1, Year: 2000		3. Time of Death 11:23 AM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-74-9964	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth Month: August, Day: 24, Year: 1948		9. Birthplace (State or Foreign) North Carolina
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bladensburg			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3801 Kenilworth Avenue				10f. Zip Code 20710		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4or 5+) 10th grade				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed			16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Eunice Campbell				
19a. Informant's Name/Relationship (Type, Print) Mrs. Margylene Haley (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Kenilworth Avenue Bladensburg, Maryland 20710				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.		Date 8/4/2000		20c. Location - City or Town, State Beltsville, Maryland
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>HEPATIC FAILURE</u> Due to (or as a consequence of): b. <u>AUTOIMMUNE HEPATITIS</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 042249		29d. Date signed (Month, Day, Year) 8/2/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND NWADIUKO, MD 9831 GREENBEE RD STE 101 KANTHAM MD 20706								
31. Date filed (Month, Day, Year) AUG 04 2000				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27

Certificate of Death

28A-F PER MEO G786 8-23-00 WR.

Reg. No.

00 26179

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kirk Williams			2. Date of Death Month Day Year AUGUST 03, 2000		3. Time of Death 22:50 PM	
	4a. Facility Name (If not institution, give street and number) MARYLAND CORRECTIONAL INSTITUTE			4b. City, Town, or Location of Death JESSUP		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 577-74-3774	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6-4-1955	9. Birthplace (State or Foreign Country) Wash., D.C.
	Usual Residence of Decedent						
10a. State		10b. County		10c. City, Town or Location Washington, D.C.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 608 Emmanuel Court, N.W. #201				10f. Zip Code 20001		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) general Labor		16b. Kind of Business/Industry Private Industry	
17. Father's Name (First, Middle, Last) James Edward Williams				18. Mother's Name (First, Middle, Maiden Surname) Alice McCall			
19a. Informant's Name/Relationship (Type, Print) Veronica L. Williams/sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Endicott Place Springdale, Md. 20774			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Cemetery		20c. Location - City or Town, State 8/12/00 Clinton, Maryland		20d. Date	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. Wash., DC 20001			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC INTOXICATION IN ASSOCIATION WITH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS							
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 8-3-00		28b. Time of Injury 10:06 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred FOUND IN JAIL CELL				28e. Location (Street and Number or Rural Route Number, City or Town, State) MARYLAND CORRECTIONAL INSTITUTE, JESSUP, MD.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
29c. License number OCME				29d. Date signed (Month, Day, Year) AUGUST 04, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) AUG 11 2000				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26177

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LETTIE M. WHEELER				2. Date of Death Month Day Year July 26 2000				3. Time of Death 11:00 a.m.													
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				4b. City, Town, or Location of Death CLINTON				4c. County of Death PRINCE GEORGE'S													
Funeral Director	5. Social Security Number 228 30 7342		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87		8. Date of Birth (Month, Day, Year) September 21, 1912		9. Birthplace (State or Foreign Country) Virginia													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number 8901 Shannan Drive				10f. Zip Code 20735				10g. Citizen of What Country? USA														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Private														
17. Father's Name (First, Middle, Last) Charlie Clark				18. Mother's Name (First, Middle, Maiden Surname) Fannie Jones																		
19a. Informant's Name/Relationship (Type, Print) Bobby Austin /nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8901 Shannan Drive Clinton, MD 20735																		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hickman Family Cemetery		Date 7/29/00		20c. Location - City or Town, State Fairlawn, Virginia																
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Pneumonia</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 week</td> </tr> <tr> <td>b. Dementia</td> <td>Due to (or as a consequence of):</td> <td>2 yr</td> </tr> <tr> <td>c. SID PEG</td> <td>Due to (or as a consequence of):</td> <td>6 months</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week	b. Dementia	Due to (or as a consequence of):	2 yr	c. SID PEG	Due to (or as a consequence of):	6 months	d.		
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week																			
	b. Dementia	Due to (or as a consequence of):	2 yr																			
	c. SID PEG	Due to (or as a consequence of):	6 months																			
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.																						
23b. Did tobacco use contribute to the causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.																						
29b. Signature and title of certifier <i>[Signature]</i> Attending				29c. License number D-24535		29d. Date signed (Month, Day, Year) 07.26.00																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Berwa, MD 7503 Surratts Rd Clinton, MD 20735																						
31. Date filed (Month, Day, Year) AUG 01 2000		32. Registrar's Signature <i>[Signature]</i>																				

97210 500

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26178

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George White

2. Date of Death

July 29 2000

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Southern Md.

4b. City, Town, or Location of Death

Clinton

4c. County of Death

P. G.

Funeral
Director

5. Social Security Number

578-48-6824

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

01-10-38

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State
D. C.

10b. County

10c. City, Town or Location
Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2315 Altamont Place, S. E. Apt. 1

10f. Zip Code

20020

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

U. S. Govt

17. Father's Name (First, Middle, Last)

George Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Inez Lewis

19a. Informant's Name/Relationship (Type, Print)

Calvin Young (Brother-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2315 Altamont Place, S. E. #1
Washington, D. C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cemetery 8-4-00

Date

20c. Location - City or Town, State

Triangle, Va.

21. Signature of Funeral Service Licensee

Wanda C. Bacon MD361

22. Name and Address of Facility

Bacon Funeral Home, Inc. 3447 14th St., N.W.
Washington, D. C. 20010

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wanda C. Bacon MD

29c. License number

D50454

29d. Date signed (Month, Day, Year)

August 1, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Arastoo Yazdani, M. D. 9801 Ga. Ave., Silver Spring, Md. 20902

State
Registrar

31. Date filed (Month, Day, Year)

AUG 01 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26180

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Jean Wheeler

2. Date of Death

Month

Day

Year

August

3 2000

3. Time of Death

1316

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

435 74 8489

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

November 13, 1947

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Washington

Clear Spring

☐ Yes ☒ No

10e. Street and Number

1338 Blair's Valley Road

10f. Zip Code

21722

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Herman Lloyd Davis

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Maylee Matthews

19a. Informant's Name/Relationship (Type, Print)

Arthur L. Wheeler Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1338 Blair's Valley Rd., Clear Spring, Md. 21722

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Century Cemetery

Date

8/8/00

20c. Location - City or Town, State

Shreveport, La.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich

305 N. Potomac St.

Funeral Home

Hagerstown, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

b. Diabetic Ketoacidosis

Due to (or as a consequence of):

c. Myocardial Infarction

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carotid Stenosis

Diabetes mellitus

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 53840

29d. Date signed (Month, Day, Year)

August 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. McGee 324 E. Antietam St. Hag. Md. 21740

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Michael C. Wangerow

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEQ. G 786 8-23-00 WR.

00 26181

AMENDMENTS: #23 PART I, 27, 28A-F PER Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Michael C. Wangerow</i>		2. Date of Death Month Day Year August 02 2000		3. Time of Death 04:50 A.M.
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital		4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford
Funeral Director	5. Social Security Number <i>NONE</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. Months Days <i>2 27</i>	8. Date of Birth (Month, Day, Year) <i>MAY 6, 2000</i>	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <i>md.</i>	10b. County <i>Cecil</i>	10c. City, Town or Location <i>Port Deposit</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <i>1300 Susquehanna River Rd.</i>		10f. Zip Code <i>21904</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>NA</i> College (1-4 or 5+) <i>NA</i>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>NA</i>		16b. Kind of Business/Industry <i>NA</i>		
	17. Father's Name (First, Middle, Last) <i>RANDAL BRAGG</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>MARJORIE Wangerow</i>		
	19a. Informant's Name/Relationship (Type, Print) <i>LuAnn Cusic, Social Worker</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>170 E. MAIN ST, EIKTON, MD. 21921</i>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>R.A. FENNIS & Co.</i>		20c. Location - City or Town, State <i>West Chester, PA.</i>
	21. Signature of Funeral Service Licensee <i>Edward M. Fennis</i>		22. Name and Address of Facility <i>Gee Funeral Home 259 E. MAIN ST. EIKTON, MD. 21921</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden Unexpected Death in Infancy Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <i>Found 8-2-00</i>					
28b. Time of Injury <i>UNKNOWN</i>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred <i>UNKNOWN</i>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>FOUND AT HOME</i>					
28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>1300 SUSQUEHANNA RIVER ROAD POST DEPOSIT, MD</i>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Dennis J. Chutemo</i>					
29c. License number <i>O.C.M.E.</i>					
29d. Date signed (Month, Day, Year) <i>August 3, 2000</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dennis Chutemo 111 Penn Street, Baltimore, Maryland 21201</i>					
31. Date filed (Month, Day, Year) <i>AUG 07 2000</i>					
32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26182

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael David ZEIGLER

2. Date of Death

Aug 03 2000

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

217-58-3979

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 1, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1401 Wellington Road

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

trucking

17. Father's Name (First, Middle, Last)

Jonas W. Zeigler

18. Mother's Name (First, Middle, Maiden Surname)

Marie V. Poffenberger

19a. Informant's Name/Relationship (Type, Print)

Teresa A. E. Zeigler - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1401 Wellington Road, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

8-5-00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Widespread Metastatic bone Carcinoma of unknown Primary

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Marie Chan, M.D.

29c. License number

D76416

29d. Date signed (Month, Day, Year)

Aug. 3, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

ROSE MARIE CHAN, M.D.

1500 Pennsylvania Avenue
Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26183

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GORTKINS ABELIAN

2. Date of Death
Month Day Year

August 17, 2000

3. Time of Death
3 AM

4a. Facility Name (If not institution, give street and number)

LORIEN NURSING HOME FRANKFORD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

218-18-0688

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

8. Date of Birth (Month, Day, Year)

9/8/08

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3941 SINCLAIR LANE

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LEWIS E. WELTY

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE B. BARRICK

19a. Informant's Name/Relationship (Type, Print)

TRUDY KEEFER GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3527 RIVER BRIDGE WAY LAUREL, MD 20724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

8/19/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Approximate Interval Between Onset and Death

DAYS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. KIDNEY OBSTRUCTION

DAYS

c. BLOOD CANCER

UNKNOWN (O'D 8100)

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD TYPE II DM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

COPD WZ. CARDIOMYOPATHY

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D41291

29d. Date signed (Month, Day, Year)

8/17/00 August 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN GITTER MD. CROSSROADS DR. #330
CROSSROADS DR. #330

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

APRIL

2000

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26184

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise E. Adams

2. Date of Death

Month Day Year
AUGUST 11 2000

3. Time of Death

2:45 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

231-28-0649

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4-23-1927

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

411 Potomac Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Moore

18. Mother's Name (First, Middle, Maiden Surname)

Eva Ester Evans

19a. Informant's Name/Relationship (Type, Print)

Geraldine Heise/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7924 35th Street, Baltimore, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garden of Faith Cem

Date

8-14-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home
1211 Chesaco Avenue, Baltimore, MD 2123723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. END STAGE LIVER DISEASE

Due to (or as a consequence of):

b. HEPATORENAL SYNDROME

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

RD 188821

29d. Date signed (Month, Day, Year)

8/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERRI DAVIS, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State
Registrar

31. Date filed (Month, Day Year)

AUG 18 2000

32. Registrar's Signature

ADAMS, LOUISE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, N

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

00 58184

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26185

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sara Arbesman

2. Date of Death
Month Day Year

August 12, 2000

3. Time of Death

7:47 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-22-4709

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 9, 1908

9. Birthplace (State or Foreign)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

5607 HIGHGATE DRIVE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No ARMY
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

REGISTERED NURSE

16b. Kind of Business/Industry

HEALTH

17. Father's Name (First, Middle, Last)

HARRY

18. Mother's Name (First, Middle, Maiden Surname)

POLONSKY

REBECCA

NACHMAN

19a. Informant's Name/Relationship (Type, Print)

GILBERT ARBESMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5607 HIGHGATE DRIVE BALTIMORE, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FRIEDEL MARYLAND LODGE

Date

8/15/00

20c. Location - City or Town, State

ROSEDALE, MD.

21. Signature of Funeral Service Licensee

Jay Allan Lewis

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD. 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Ischemic cardiomyopathy
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Alice Hirsch

29c. License number

H45974

29d. Date signed (Month, Day, Year)

August 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice Hirsch Northwest Hospital Randallstown, Md

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Gene B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-2000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26186

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine

Arbutis

2. Date of Death

Month Day Year
August 16 2000

3. Time of Death

1:45 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-16-1853

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Sept. 2, 1923

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1862 Marshall Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yrs.

College (1-4 or 5+)
2 Yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond John Rugemer

18. Mother's Name (First, Middle, Maiden Surname)

Edna E. Specht

19a. Informant's Name/Relationship (Type, Print)

John Arbutis Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1862 Marshall Rd. Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn Cemetery

Date

Aug 21, 2000

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Rd. Dundalk, Md. 21222

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. chronic lymphocytic leukemia

Due to (or as a consequence of):

c. malnutrition

Due to (or as a consequence of):

d. Aspiration Pneumonia

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sacral decubitus ulcer stage IV

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Lisa Deyerte MD

29c. License number

RD203489

29d. Date signed (Month, Day, Year)

8/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR LISA Deyerte 9000 Franklin Square Drive Baltimore MD 21237

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

ARBUSIS, ELAINE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

174

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26187

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Germaine

Rommell

Brown III

2. Date of Death
Month Day Year

August

13

2000

3. Time of Death

9:20 pm

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month Day Year

8-13-2000

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

1107 Harwall Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Germaine Rommell Brown II

18. Mother's Name (First, Middle, Maiden Surname)

Julie Brooks

19a. Informant's Name/Relationship (Type, Print)

Julie M. Brooks-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1107 Harwall Road, Baltimore Md 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 8/18/00 Randallstown, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Congenital Anomalies

1 hour

Due to (or as a consequence of):

b. Possible Trisomy 18

1 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30206

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven H. Pearlman, M.D. Greater Baltimore Medical Center Baltimore MD 21204

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#1 PER MD. G786 8-18-2000 JAB

Certificate of Death

Reg. No.

00 26188

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Boy Lakisha Barnes

2. Date of Death

July 14 2000

3. Time of Death

3:30pm

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

Unknown

6. Sex

M 20 F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

7-14-00

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

729 mello Court

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1X Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Lakisha Barnes

19a. Informant's Name/Relationship (Type, Print)

Lakisha Barnes/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

729 mello Court - Balto. MD. 21205

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Johns Hopkins Hospital

Date

7/15/00

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

Deborah Evans

22. Name and Address of Facility

SHH-600 N. Wolfe St-21287

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Extreme Prematurity

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 2X No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 2X No

25. Was case referred to medical examiner?

10 Yes 2X No

Hospital:

1X Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

1X Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide
40 Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yue-chung Yang

29c. License number

D23369

29d. Date signed (Month, Day, Year)

7-14 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YUE-CHUNG YANG, 1000 East Eager Street, Baltimore MD 21202

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26189

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NATHANIEL BLAND

2. Date of Death

Month Day Year
AUGUST 14, 2000

3. Time of Death

5:27 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-30-5778

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 12, 1936

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10e. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3408 CARDINAL COURT

10f. Zip Code

21207

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA BLAND

19a. Informant's Name/Relationship (Type, Print)

PAMELA SMITH (NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 N. BENTALOU STREET, BALTO, MD. 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRISON FOREST

Date

8-22-00 OWINGS MILLS, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTIMORE, MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

1 HOUR

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

YEARS

Due to (or as a consequence of):

c. HYPERTENSIVE CARDIOVASCULAR DISEASE

YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D47587

29d. Date signed (Month, Day, Year)

AUGUST 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT FINE, MD, 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26190

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THERESA HELEN BIRX			2. Date of Death Month Day Year AUGUST 15, 2000		3. Time of Death 12:45 PM	
	4a. Facility Name (If not institution, give street and number) HEART HOMES ASSISTED LIVING			4b. City, Town, or Location of Death LINTHICUM		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 306-20-3982	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 30, 1918	9. Birthplace (State or Foreign Country) INDIANA
	Usual Residence of Decedent						
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location LINTHICUM		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 400 ANDOVER ROAD			10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) MARTIN KAPICA			18. Mother's Name (First, Middle, Maiden Surname) AGNES NAWROT				
19a. Informant's Name/Relationship (Type, Print) MRS. LINDA WIENECKE (DAUGHTER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2134 BUELL DRIVE, FALLSTON, MARYLAND 21047				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER, LLC.		20c. Location - City or Town, State STEVENSVILLE, MD.		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. SECONDARY SEPTIC SHOCK Due to (or as a consequence of): c. AND GASTROINTESTINAL BLEEDING Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 		29c. License number 042041		29d. Date signed (Month, Day, Year) 08/16/2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEGANDRO, ELI B. 4115 RITCHIE HIGHWAY, BROOKLYN PARK, MD. 21225							
31. Date filed (Month, Day, Year) AUG 18 2000			32. Registrar's Signature 				

ORIGINAL

AND PARTIAL LATE LATE SECTION
STATIONED BETWEEN 1000 AND 1100
CAL. 1000 M. L. 1000 M. L. 1000 M. L.

1000 M. L. 1000 M. L. 1000 M. L.

1000 M. L. 1000 M. L. 1000 M. L.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26191

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS MARJORIE MARTIN BARTON				2. Date of Death Month August Day 11 Year 2000		3. Time of Death 7:00 A.M.	
	4a. Facility Name (If not institution, give street and number) EDENWALD				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore County	
Funeral Director	5. Social Security Number 213-48-6609		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Nov 17, 1910	
	9. Birthplace (State or Foreign Country) Michigan		10a. State Maryland		10b. County Baltimore County		10c. City, Town or Location Towson	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 800 Southerly Road		10f. Zip Code 21286		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Residence		
17. Father's Name (First, Middle, Last) Charles W. Martin				18. Mother's Name (First, Middle, Maiden Surname) Ida Eicher				
19a. Informant's Name/Relationship (Type, Print) (Dghtr) Marjorie Price Barton Richmond				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2360 Flax Terrace, Baltimore, Maryland 21209				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Date 8/17/2000		20d. Location - City or Town, State Pikesville, Maryland		
21. Signature of Funeral Service Licensee Martin D. Lawson		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. Lung Cancer Due to (or as a consequence of):</p> <p>b. Severe chronic obstructive lung disease Due to (or as a consequence of):</p> <p>c. Asperose schistoc disease Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 5%;"> <p>Approximate Interval Between Onset and Death</p> <p>2 yrs</p> <p>10 yrs</p> <p>10 yrs</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Marcelino D. Albuerno		29c. License number D 29769		29d. Date signed (Month, Day, Year) 8/14/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcelino D. Albuerno, M.D., 800 Southerly Road, Towson, MD 21286								
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature Beverly S. Sparks						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26192

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Steven Wayne Benson

2. Date of Death

Month Day Year
August 17, 2000

3. Time of Death

1:32 pm

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218 58 8213

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 21, 1951

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

212 Stevens Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

George Benson

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Little

19a. Informant's Name/Relationship (Type, Print)

Richard W. Benson (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11537 Franklinville Rd. Upper Falls, Md. 21152

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory 8/18/2000

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Brudzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Benson

State
Registrar

AUGUST 17, 2000 1:32 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2028.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

STEVEN WAYNE BENSON

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26193

amend item 7 per fh G786 8/21/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Edward Biglen		2. Date of Death Month August Day 12 Year 2000		3. Time of Death 4:32 pm
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 213-36-7117	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) August 2, 1938		9. Birthplace (State or Foreign Country) Pennsylvania		
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3212 Everlasting Lane			10f. Zip Code 21220		10g. Citizen of What Country? U. S. A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-1959		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry Trucking Industry
17. Father's Name (First, Middle, Last) William Biglen			18. Mother's Name (First, Middle, Maiden Surname) Doris Cosgrove		
19a. Informant's Name/Relationship (Type, Print) Diane Biglen (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 Everlasting Lane Middle River, MD 21220		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematorium		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC PROSTATE CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number RD203372		29d. Date signed (Month, Day, Year) AUGUST 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Regina Gan-Carden 9000 Franklin Square Drive Baltimore MD 21237					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26194

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joel Bratton, Jr.				2. Date of Death Month Day Year AUG. 10, 2000		3. Time of Death 3:30 AM	
	4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a	
Funeral Director	5. Social Security Number 212-90-6479		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 35 Yrs.		8. Date of Birth (Month, Day, Year) July 7, 1965	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1111 Shields Place			
	10f. Zip Code 21201				10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper		16b. Kind of Business/Industry Millenium of Franklin Square Nursing Home			
	17. Father's Name (First, Middle, Last) Joel Bratton, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Betty Holliday			
	19a. Informant's Name/Relationship (Type, Print) mother Betty Abdul-Ali				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Shields Place Baltimore, MD 21201			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Date Aug 12		20d. Location - City or Town, State Baltimore County, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple gunshot wounds Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8-10-2000		28b. Time of Injury unknown		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred subject was shot		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) sidewalk		28f. Location (Street and Number or Rural Route Number, City or Town, State) 782 Linand Street Baltimore City, Maryland				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 10, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26195

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl C. Brackett				2. Date of Death Month Day Year August 14 2000				3. Time of Death 0730	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a	
Funeral Director	5. Social Security Number 212-36-8985		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 6, 1917		9. Birthplace (State or Foreign Country) Md.		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4100 N. Charles Street Unit 704				10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator				16b. Kind of Business/Industry Baltimore City Public Schools			
	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Rosina Thompson					
	19a. Informant's Name/Relationship (Type, Print) Lydia W. Mussenden friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 N. Charles Street Unit 1114 Balto. Md. 21218					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		Date Aug. 18		20c. Location - City or Town, State Baltimore, Md.	
	21. Signature of Funeral Service Licensee Herbert E. Nutter				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				a. intracranial hemorrhage with compression of brainstem Due to (or as a consequence of): through femoral vein				Approximate Interval Between Onset and Death 40 hours	
	b. _____ Due to (or as a consequence of):				c. _____ Due to (or as a consequence of):				d. _____	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Thomas Linberg MD				29c. License number AN 4176435L				29d. Date signed (Month, Day, Year) August 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Linberg M.D. 4216 Sugar Pine Court, Burtonsville, MD 20866										
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature Benjamin Sparks								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26196

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine Olga Breen

2. Date of Death

Month Day Year
August 16 2000

3. Time of Death

9:12 PM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-20-1787

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hour Min.

8. Date of Birth

(Month, Day, Year)
APR 23, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

143 W. Hill Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

George Niebuhr

18. Mother's Name (First, Middle, Maiden Surname)

Erna Degler

19a. Informant's Name/Relationship (Type, Print)

Martin Stephen Breen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

51 Reed Road Oakdale, CA 95361

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

8-17-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn McDonald

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide ☐ Could not be determined
☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Anthony Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

August 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley OBMC 06701 N. Charles St. Balto. MD 21204

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Beverly B. Sparks

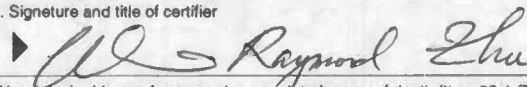
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26197

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Nell Custer				2. Date of Death Month August Day 11 Year 2000		3. Time of Death 1245 AM		
	4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 245-46-7921		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) November 18, 1934		
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2 Glencoe Ave		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) James Webb		18. Mother's Name (First, Middle, Maiden Surname) Nina Launia Spivey	
19a. Informant's Name/Relationship (Type, Print) Mr. Gary A. Custer Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Glencoe Ave Catonsville, Maryland 21228		20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Park		20c. Location - City or Town, State Sykesville, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Congestive heart failure Due to (or as a consequence of): d. Diabetes mellitus		Approximate Interval Between Onset and Death 3 hrs 5 hrs 2 weeks years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension S/P cerebrovascular accident Rheumatic heart disease		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  RAYMOND ZHU		29c. License number D0056143		29d. Date signed (Month, Day, Year) 8/11/2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WEIMIN RAYMOND ZHU		31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 		33. Name and address of person who completed cause of death (Item 23e) (Type, Print) ST. AGNES HOSPITAL, BALTIMORE, MARYLAND			

2000

08 3 1 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26198

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Olevia A. Cherry

2. Date of Death

Month Day Year
August 15, 2000

3. Time of Death

10:05 a.m.

4a. Facility Name (If not institution, give street and number)

Manor Care

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-84-6536

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 27, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2124 Oakland Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lewis K. Heck

18. Mother's Name (First, Middle, Maiden Surname)

Mary F. Patterson

19e. Informant's Name/Relationship (Type, Print)

Alan E. Cherry (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2124 Oakland Road, Baltimore, Maryland 21220

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Mem. Gardens 8/19/2000 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Due to (or as a consequence of):

ASCD

Approximate
Interval Between
Onset and Death

3 mos.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24e. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D45425

29d. Date signed (Month, Day, Year)

8/15/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mohamed Rahnama, 19 Fontana Lane, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registered Signature

[Signature]

State
RegistrarOlevia Cherry 8-15-00 10:05 AM
3-27-1911

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26199

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor Louise Conaway				2. Date of Death Month: August, Day: 15, Year: 2000				3. Time of Death 2:24 P.M.	
	4a. Facility Name (If not institution, give street and number) 808 East Seminary Ave.				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 119-07-4979		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) April 19, 1913		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2 Acorn Circle Apt. 201				10f. Zip Code 21286	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator	
	16b. Kind of Business/Industry Bank				17. Father's Name (First, Middle, Last) William E. Conaway				18. Mother's Name (First, Middle, Maiden Surname) Frances Plubel	
	19a. Informant's Name/Relationship (Type, Print) Mrs. Emily C. Miles / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 E. Seminary Ave. Towson, Maryland 21286				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
	20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys Cemetery				20c. Date 8/21/2000				20d. Location - City or Town, State Frenchville, Pa.	
	21. Signature of Funeral Service Licensee Earl L. Canapp, CFSP				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Coronary Heart Disease Due to (or as a consequence of):	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier				29c. License number D-17041				29d. Date signed (Month, Day, Year) 15 August 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARC I. LEAVEY, MD 1205 YORK ROAD STE 38 LUTHERVILLE MD 21093				31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature B Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26200

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Dunbar				2. Date of Death Month August Day 10 Year 2000		3. Time of Death 0517	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 249-30-1203		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 11/20/23	
	9. Birthplace (State or Foreign Country) unknown		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4946 Denmore Avenue		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown		17. Father's Name (First, Middle, Last) unknown		
18. Mother's Name (First, Middle, Maiden Surname) unknown		19a. Informant's Name/Relationship (Type, Print) Johns Hopkins Bayview Med. Ctr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4940 Eastern Ave., Baltimore, MD 21205		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in-state		
20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board, 655 W. Baltimore Street		20c. Location - City or Town, State Baltimore, MD 21201		21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street		
22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. aspiration pneumonia		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year) August 10, 2000		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Johns Hopkins Bayview Medical Center		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4940 Eastern Ave		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Antonia Bruno, MD		
29c. License number 20300		29d. Date signed (Month, Day, Year) August 10, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Medical Center		31. Date filed (Month, Day, Year) AUG 18 2000		
32. Registrar's Signature Benita B. Spauls		33. Date of Death August 10, 2000		34. Time of Death 0517		35. Race - American Indian, Black, White, etc. Black		

00-4508-027

Larry DOVE
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM#23 PART I PER MEO G787 8-5-00 WR
State of Maryland Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G786 8-24-00 WR.

Certificate of Death

Reg. No.

00 26201

Baltimore, Maryland 21215-0020


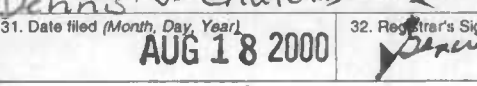
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Larry Ronald Dove				2. Date of Death Month AUGUST Day 11 , Year 2000		3. Time of Death 7:08 P.M.	
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 218-62-2033		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) January 10, 1951	
	9. Birthplace (State or Foreign Country) MD		10a. State Maryland		10b. County Howard		10c. City, Town or Location Jessup	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7615 Washington Blvd		10f. Zip Code 20794		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk at the Distribution Center		16b. Kind of Business/Industry Sunny's Surplus				
17. Father's Name (First, Middle, Last) Harold Benjamin Dove, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Agnes M. Delp				
19a. Informant's Name/Relationship (Type, Print) Mr. Benny Dove Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2774 St. Johns Lane Ellicott City, Maryland 21042				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery		Date 08/16/2000		20c. Location - City or Town, State Ellicott City, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE ETHANOL AND ACUTE NARCOTIC INTOXICATION		Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____		Approximate interval between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 8-11-00		28b. Time of Injury 5:30 P.M.		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN MOTEL ROOM		28f. Location (Street and Number or Rural Route Number, City or Town, State) #34 JESSUP, MD.		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 12, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, Penn Street Baltimore, MD 21201		31. Date filed (Month, Day, Year) AUG 18 2000						
32. Registrar's Signature 		33. Registrar's Name B. Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26202

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lloyd M. Dutton

2. Date of Death

Month Day Year
08-16-2000

3. Time of Death

8:30AM

4a. Facility Name (If not institution, give street and number)

2813 Parkwood Ave 21217

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

218-10-5834

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
JULY 25, 1918

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2813 PARKWOOD AVENUE

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

TELEPHONE CO.

17. Father's Name (First, Middle, Last)

WILLIAM H. DUTTON

18. Mother's Name (First, Middle, Maiden Surname)

SIDNEY GASSAWAY

19a. Informant's Name/Relationship (Type, Print)

BERNICE DUTTON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2813 PARKWOOD AVENUE BALTO., MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VET. CEM

Date

8/21/2000

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC

1701 LAURENS ST. BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Colon Cancer

Approximate Interval Between Onset and Death

1 year

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D15450

29d. Date signed (Month, Day, Year)

8/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Al-Ibrahim, M.D. 10 N. Greene St. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

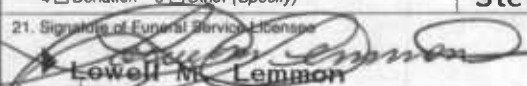

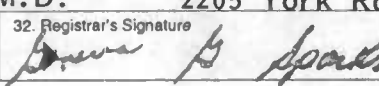
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26203

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth S. Dorsey				2. Date of Death Month Day Year Aug. 16 2000		3. Time of Death 1:30 AM	
	4a. Facility Name (If not institution, give street and number) 817 E. Quaker Bottom Rd.				4b. City, Town, or Location of Death Sparks		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-12-5789		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 6 1920	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Sparks			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 817 E. Quaker Bottom Rd.				10f. Zip Code 21152		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) n/a				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Handler		16b. Kind of Business/Industry Telephone Co.		
17. Father's Name (First, Middle, Last) Hezekiah Stewart				18. Mother's Name (First, Middle, Maiden Surname) Betty Clark				
19a. Informant's Name/Relationship (Type, Print) Howard Dorsey, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 E. Quaker Bottom Rd., Sparks, MD 21152				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stevenson AME Church Cem.		Date 8/19/00		20c. Location - City or Town, State Sparks, MD		
21. Signature of Funeral Service Licensee  Lowell M. Lemmon				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  MD				29c. License number 039050		29d. Date signed (Month, Day, Year) 8/16/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard Raucher, M.D. 2205 York Rd., Timonium, MD 21093								
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature  Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26204

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linda

Rose

Elliott

2. Date of Death

Month

Day

Year

AUGUST 16, 2000

3. Time of Death

10:40 AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

212-48-2921

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
July 4, 1947

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2809 Dungen Ct.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 yrs

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Elmer Francis Wisner

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Ruth Hembree

19a. Informant's Name/Relationship (Type, Print)

Nancy Leonard sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7816 Eddlynn Rd. Dundalk, Md. 21222

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

Aug 17,

2000

20c. Location - City or Town, State

Catonsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Rd. Dundalk, Md. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

HYPERTENSION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARBI GHAZARIAN, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26205

Certificate of Death

Reg. No.

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) JESSIE ERVIN		2. Date of Death Month AUG Day 15 Year 2000		3. Time of Death 12 50 AM
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 238-52-1527	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 12-2-1935		9. Birthplace (State or Foreign Country) N.C.		
Usual Residence of Decedent					
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 501 E. PRESTON ST.			10f. Zip Code 21202		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) CONSTRUCTION WORKER		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) JOHN ERVIN		18. Mother's Name (First, Middle, Maiden Surname) LILLIE MAE ERVIN			
19a. Informant's Name/Relationship (Type, Print) MICHAEL ERVIN (SON)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6638 EBELE DR. BALTO. MD 21215			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State 8-18-2000 CATONSVILLE MD	
21. Signature of Funeral Service Licensee EUGENE WALKER		22. Name and Address of Facility ESTEP BROS. FUNERAL SERV. 1300 EUTAW PLACE BALTO. MD 21217			
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. END STAGE LIVER DISEASE Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier J. Sumner		29c. License number D30272		29d. Date signed (Month, Day, Year) 8/15/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS HOSPITAL BALTIMORE, MARYLAND					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature G. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26206

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Delores Ellis

2. Date of Death

Month
08Day
11Year
2000

3. Time of Death

2302

4a. Facility Name (If not institution, give street and number)

1603 East Eager St

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

214-50-3402

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
05/28/1949

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1603 E. Eager St.

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Steel Mill

17. Father's Name (First, Middle, Last)

Joseph Wilson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Eaddy

19a. Informant's Name/Relationship (Type, Print)

Chrystal Green

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2602 Gehb Ave.,

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion

Date

8/18/00 Lansdowne Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Chavis Funeral Home, P.A., 2007-09 Eastern Av.
Baltimore, MD 21231 - (410) 342-740023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?INSPECTION
1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPLEY, M.D. 111 Penn Street Baltimore, Md. 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
0000.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26207

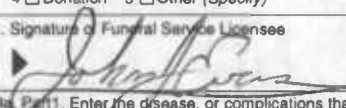


Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTELLE FISHMAN		2. Date of Death Month Day Year AUGUST 16, 2000		3. Time of Death 1:00 PM
	4a. Facility Name (If not institution, give street and number) 4818 STONE SHOP CIRCLE		4b. City, Town, or Location of Death OWINGS MILLS		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 039-16-9481	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) AUG. 4, 1928		9. Birthplace (State or Foreign Country) CT		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location OWINGS MILLS		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 4818 STONE SHOP CIRCLE		10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry SPECIAL EDUCATION		
	17. Father's Name (First, Middle, Last) HARRY WEINSTEIN		18. Mother's Name (First, Middle, Maiden Surname) FANNIE LUCHANSKY		
	19a. Informant's Name/Relationship (Type, Print) AUDRA CAPLAN / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 CALVIN AVENUE, BALTIMORE, MD 21218		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHEVRA AHAVAS CHESD		20c. Location - City or Town, State 8/17/00 RANDALLSTOWN, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non Hodgkins Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 4 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
State Registrar	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier  Janet Cooper MD		29c. License number D46118		29d. Date signed (Month, Day, Year) Aug 17, 2000
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Janet Cooper MD 1447 York Rd Lutherville MD 21093					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26208

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALEXANDER BERNANDEZ				2. Date of Death Month Day Year AUGUST 14, 2000		3. Time of Death 4:40 AM	
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 233-28-5077		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 78		8. Date of Birth (Month, Day, Year) Sept. 8, 1921	
	9. Birthplace (State or Foreign Country) Rome, New York		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Pikesville	
Usual Residence of Decedent				10d. Inside City Limits 1 Yes 2 No				
10e. Street and Number 4515 Tapscott Road				10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Spaniard		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Industrial Engineer		16b. Kind of Business/Industry Westinghouse		
17. Father's Name (First, Middle, Last) Manuel Fernandez				18. Mother's Name (First, Middle, Maiden Surname) Francisca Borbolla				
19a. Informant's Name/Relationship (Type, Print) Carmen Fernandez (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Tapscott Road, Pikesville, Maryland 21208				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		20c. Date 8/24/00		20d. Location - City or Town, State Arlington, Virginia		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, MD 21133				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic Due to (or as a consequence of): Gram Positive cocci Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Septic Due to (or as a consequence of): Gram Positive cocci Due to (or as a consequence of): Septic Due to (or as a consequence of): Gram Positive cocci								
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
24a. Was an autopsy performed? 1 Yes 2 No								
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Long Aneurysm Encephalopathy								
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D44505		29d. Date signed (Month, Day, Year) AUGUST 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AS IMPERIO, Jr. MD - NWHC								
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26209

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Thomas Galvin Foster, Sr.

2. Date of Death

Month Day Year
August 14 2000

3. Time of Death

1:45 a.m.

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Spa Creek

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

218-16-2273

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 2, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

926 Boom Way

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Air Force Pilot

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

George Ivanhoe Foster

18. Mother's Name (First, Middle, Maiden Surname)

Mary Matilda Adams

19a. Informant's Name/Relationship (Type, Print)

Thomas G. Foster, Jr./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

926 Boom Way Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cemet. 8/28/00 Washington, D. C.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. O. Mitchell

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd., Baltimore, Maryland 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Cardiomyopathy

b.

Due to (or as a consequence of):

Arteriosclerotic vascular lesion

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

6m

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. O. Mitchell

29c. License number

D32036

29d. Date signed (Month, Day, Year)

8/14/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gay J. Fosse 2108 P. Dunham Drive Chaster, MD 21619

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

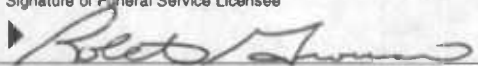

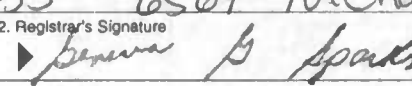
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26211

AMEND#8,10E,19A PER F.H. G786 8-18-2000 JAB **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FANNIE GUREVITCH			2. Date of Death Month AUG Day 12 Year 2000		3. Time of Death 4:15PM	
	4a. Facility Name (If not institution, give street and number) 7 SLADE AVE APT# 304			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-36-1678		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) MAR 17 1915
	9. Birthplace (State or Foreign Country) MD						
Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 7 SLADE AVE. APT. 304			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REAL ESTATE AGENT		16b. Kind of Business/Industry REAL ESTATE		
17. Father's Name (First, Middle, Last) ISAAC NADICH				18. Mother's Name (First, Middle, Maiden Surname) LENA NATHANSON			
19a. Informant's Name/Relationship (Type, Print) LEE SACHS/SON LEE SACHS/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10504 CASCADE RUN COURT OWINGS MILLS, MD. 21117			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH TFILOH CONGREGATION		Date 8/14/00		20c. Location - City or Town, State WOODLAWN, MD.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of): b. Anemia Due to (or as a consequence of): c. Hyperlipidemia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D23985		29d. Date signed (Month, Day, Year) 8/12/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joyce Y Gross 6569 N. Charles St Balto 21204							
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26212

AMEND#20B PER F.H. G786 8-18-2000 JAB

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Baby Girl Gudibande						2. Date of Death Month Day Year June 29 2000			3. Time of Death 0445		
	4a. Facility Name (If not Institution, give street and number) Shady Grove Adventist Hospital						4b. City, Town, or Location of Death Rockville, Maryland			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number NONE		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 6		8. Date of Birth (Month, Day, Year) June 28, 2000		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 211 Cherrywood Terrace				10f. Zip Code 20878				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: ASIAN INDIAN			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INFANT				16b. Kind of Business/Industry INFANT			
	17. Father's Name (First, Middle, Last) SATYA R. Gudibande						18. Mother's Name (First, Middle, Maiden Surname) Radha Seshadri					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Radha Gudibande mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Cherrywood Terrace Gaithersburg Md. 20878					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Shady Grove Adventist				20c. Location - City or Town, State Rockville MD		20d. Date 7/31/2000	
	21. Signature of Funeral Service Licensee Deborah A. G...						22. Name and Address of Facility Shady Grove Adventist 9901 Med. Cntr. Dr. Rockville Md 20850					
	23a. Part I. Enter the disease, or complication, or cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. premature delivery induced Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. trauma 21										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. Johnson MD		29c. License number D37805		29d. Date signed (Month, Day, Year) 6/28/00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Johnson, MD, 501 N. Frederick Ave, Gaithersburg, MD 20877												
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature James B. Sparks										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26213

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Irene Guetler				2. Date of Death Month Day Year August 16 2000		3. Time of Death 6 AM	
	4a. Facility Name (If not institution, give street and number) Alice Manor Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-07-9377		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) February 1 1916	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10a. State Maryland			10b. County N/A			10c. City, Town or Location Baltimore		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			10e. Street and Number 524 N. Charles Street #800			10f. Zip Code 21201		
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Food Service			17. Father's Name (First, Middle, Last) Lawrence Harris		
18. Mother's Name (First, Middle, Maiden Surname) Sara Reynolds			19a. Informant's Name/Relationship (Type, Print) Jean C. Bronson (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6934 Orchid Lane Dallas, Texas 75230		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens			20c. Location - City or Town, State Timonium, Maryland		
21. Signature of Funeral Service Licensee Steven T. Zittle			22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrhythmia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Richard L. Diamond			29c. License number D23076		
29d. Data signed (Month, Day, Year) August 16, 2000			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard L. Diamond, M.D. 3730 Falls Road Baltimore, Maryland 21211			31. Date filed (Month, Day, Year) AUG 18 2000		
32. Registrar's Signature Jennifer B. Sparks			33. State Registrar			34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26214

amend item 26 per verbal response G786 8/18/00 yg Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN OLIVER GOODWIN, SR.						2. Date of Death Month Day Year August 7, 2000		3. Time of Death 8:00 PM	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital						4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 216-24-4466		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 14, 1928		9. Birthplace (State or Foreign Country) Md.	
	Usual Residence of Decedent									
10a. State Md.		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 903 Boxwood Ave.				10f. Zip Code 21157		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Butcher			16b. Kind of Business/Industry Esskay Meats			
17. Father's Name (First, Middle, Last) John Oliver Goodwin						18. Mother's Name (First, Middle, Maiden Surname) Theresa R. Hubert				
19a. Informant's Name/Relationship (Type, Print) Mrs. Ada Ruth Goodwin/wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Boxwood Ave. Westminster, Md. 21157				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial		Date 8/11/00		20c. Location - City or Town, State Middle River, Md.		
21. Signature of Funeral Service Licensed				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC SMALL CELL CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 m	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of Certifier Flavio Kruter MD				29c. License number D35378		29d. Date signed (Month, Day, Year) 8-9-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter, MD. 224 Washington Heights Medical Center Westminster Md. 21157										
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26215

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William Glasgow</i>				2. Date of Death Month <i>Aug</i> Day <i>14</i> Year <i>2000</i>				3. Time of Death <i>12:45AM</i>						
	4a. Facility Name (If not institution, give street and number) <i>Lorien Nursing Home</i>				4b. City, Town, or Location of Death <i>Columbia</i>				4c. County of Death <i>Howard</i>						
Funeral Director	5. Social Security Number <i>220-01-9212</i>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>85Yrs.</i>		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <i>August 20, 1914</i>		9. Birthplace (State or Foreign Country) <i>MD</i>		
	Usual Residence of Decedent														
10a. State <i>MD</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Columbia</i>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>6336 Cedar Lane Apt 171</i>						10f. Zip Code <i>21044</i>				10g. Citizen of What Country? <i>U.S.A.</i>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unk.</i> College (1-4 or 5+) <i>College</i>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Insurance Agent</i>				16b. Kind of Business/Industry <i>Insurance</i>					
17. Father's Name (First, Middle, Last) <i>Clarence Glasgow</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Sadie Boston</i>									
19a. Informant's Name/Relationship (Type, Print) <i>Mr. Michael S. Glasgow Son</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6260 Kind Rain Court Columbia, Maryland 21045</i>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Old Mardella Cemetery</i>				Date <i>08/17/2000</i>		20c. Location - City or Town, State <i>Mardella Springs, MD</i>					
21. Signature of Funeral Service Licensee <i>Timothy S. Hill</i>						22. Name and Address of Facility <i>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</i>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Cerebral vascular event</i> Due to (or as a consequence of): <i>b. Cerebral vascular disease</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death <i>WKS</i> <i>Yrs</i>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier <i>Dr. [Signature]</i>						29c. License number <i>D-34860</i>				29d. Date signed (Month, Day, Year) <i>08-15-2000</i>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Diana 11055 Little Pasture Parkway, Columbia, MD 21044</i>															
31. Date filed (Month, Day, Year) <i>AUG 18 2000</i>						32. Registrar's Signature <i>[Signature]</i>									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26216

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOLAN HURTT

2. Date of Death

August 14 2000

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

H/A

Funeral
Director

5. Social Security Number

218-28-1836

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

MAR 14 1933

9. Birthplace (State or Foreign

BALTIMORE, MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7944 BELRIDGE ROAD APT. A

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SEAMAN

16b. Kind of Business/Industry

MERCHANT MARINE

17. Father's Name (First, Middle, Last)

EDWIN

HURTT

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH

ADDISON

19a. Informant's Name/Relationship (Type, Print)

JEFFREY FRANKLIN/SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2803 ONYX ROAD PARKVILLE, MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

OAK LAWN

Date

8/16/00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Benton H. Levinson

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage renal disease due to DM

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia - multi - infarct due to HTN

Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

osteomyelitis

decubitus ulcers to sacrum, @ heels.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. A. Reome MD

29c. License number

D47479

29d. Date signed (Month, Day, Year)

8/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kim Vaughn CRNP 5505 Hopkins Bayview Circle Balt. MD 21224

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Beverly B. Spotts

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26217

AMENDI ITEMS: #23 PART I, 27 PER ME Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Joseph Hamilton		2. Date of Death Month AUGUST Day 12 Year 2000		3. Time of Death 10:10 P.M.
	4a. Facility Name (If not institution, give street and number) MARYLAND HOUSE OF CORRECTIONS		4b. City, Town, or Location of Death JESSUP		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 220-40-7880	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug 5, 1942		9. Birthplace (State or Foreign Country) Balto., MD		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		
	10b. County Anne Arundel		10c. City, Town or Location Jessup		
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number Maryland House of Corrections P.O. Box 534 Route 175		10f. Zip Code 20794		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Long Shoreman		16b. Kind of Business/Industry Ship Yard
	17. Father's Name (First, Middle, Last) Carroll E. Wilgis, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Mary Esposito		
	19a. Informant's Name/Relationship (Type, Print) Albert W. Hamilton, Sr. (Brother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Marley Neck Rd. Glen Burnie, MD 21060		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 8/18/00 Beltsville, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION Due to (or as a consequence of): HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE				Approximate Interval Between Onset and Death
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) august 13, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TAUS, M.D. 111 Penn Street, Baltimore, Maryland 21201		
	31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26218

CYNTHIA HINTON

amend item 29d per me G786 8/18/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Cynthia J. Hinton</i>				2. Date of Death Month Day Year <i>AUG. 12, 2000</i>		3. Time of Death <i>0743 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>SINAI HOSPITAL E.R.</i>				4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>212-60-5520</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>47</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct 1, 1952</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>1947 N. Payson St.</i>				10f. Zip Code <i>21217</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Manager</i>			16b. Kind of Business/Industry <i>stop, shop + save store</i>	
17. Father's Name (First, Middle, Last) <i>Joseph Johnson</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Lennie Ball</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Lennie Ball / mother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>124 W. Franklin St Balt. MD 21201 (Apt. 114)</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>At Zion Cem.</i>		Date <i>8/18/2000</i>		20c. Location - City or Town, State <i>Lansdowne, MD</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Hari P. Close Funeral Service, P.A 709 Tessler St, Balt., MD 21201</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. GUNSHOT WOUNDS(2) of HEAD</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. _____ Due to (or as a consequence of):</i> <i>c. _____ Due to (or as a consequence of):</i> <i>d. _____</i>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <i>8/12/00</i>		28b. Time of Injury <i>A M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>SUBJECT SHOT</i>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>HOME</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>1912 N. PAYSON STREET BALTIMORE, MD</i>		
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>O.C.M.E</i>		29d. Date signed (Month, Day, Year) <i>AUG. 13, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>JACK M. TIUS, M.D. 111 Penn Street, Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>AUG 18 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26219

Amended Item#12 perDVR G786 8/18/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William E Junis				2. Date of Death Month August Day 17th Year 2000		3. Time of Death 6:20 AM	
	4e. Facility Name (If not institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 217-26-7837	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 23, 1911		9. Birthplace (State or Foreign Country) Ill.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3368-A N. Chatham Road				10f. Zip Code 21042		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farm		
17. Father's Name (First, Middle, Last) Peter P. Junis				18. Mother's Name (First, Middle, Maiden Surname) Louise Billiet				
19a. Informant's Name/Relationship (Type, Print) Linda C. Cavey Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6621 Marvin Ave. Eldersburg, Maryland 21784				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gardens		Date 08/19/2000		20c. Location - City or Town, State Marriottsville, Maryland		
21. Signature of Funeral Service Licensee Timothy S. Han 101113				22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extensive Right hemisphere stroke Due to (or as a consequence of): b. Atherosclerotic cardiovascular disease Due to (or as a consequence of): c. Atrial fibrillation Due to (or as a consequence of): d. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 10 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Right Pneumothorax - lung Cancer Benign prostate hyperplasia						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Junis MD				29c. License number D31927		29d. Date signed (Month, Day, Year) Aug. 17. 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ho-Lai Feng, MD. Two Knoll North Dr. Columbia. MD 21045								
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature Benita S. Sparks						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26220

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSALIE LILLIAN JONES				2. Date of Death Month Day Year August 14 2000		3. Time of Death 0920	
	4a. Facility Name (If not institution, give street and number) SUNBRIDGE NURSING CENTER				4b. City, Town, or Location of Death ELKTON		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 216-20-2745		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) NOV 9 1924	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location HAVRE DE GRACE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 905 ERIE ST.		10f. Zip Code 21078	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIETIAN				16b. Kind of Business/Industry UNIV HOSPITAL CENTER		17. Father's Name (First, Middle, Last) CHARLES MALLORY	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) HENRIETTA MALLORY				19a. Informant's Name/Relationship (Type, Print) Norma Weldon/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Revere Dr., Virginia Beach, VA., 23456	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BERKLEY CEMETERY		20c. Location - City or Town, State 8-17-00 DARLINGTON, MARYLAND	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Charles H. Powell</i>				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S. PHILADELPHIA BLVD, ABERDEEN, MD			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CVA Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Diabetes mellitus Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 wks			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Jui Chih Hsu MD</i>			
	29c. License number D04823				29d. Date signed (Month, Day, Year) 8/13/2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUI CHIH HSU, MD 2213 N. Main St. Elkton Md 21921				31. Date filed (Month, Day, Year) AUG 18 2000			
	32. Registrar's Signature <i>[Signature]</i>				33. Registrar's Title Registrar			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26221

amend item 25,27,29a per Phys. G786 8/18/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES JACKSON				2. Date of Death Month Day Year AUGUST 03 2000		3. Time of Death 6:30 pm		
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-44-0964		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) 3-6-46		
	9. Birthplace (State or Foreign Country) MD-USA		10a. State MD.		10b. County BALTO.		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2103 Chelsea Terr		10f. Zip Code 21216		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker		16b. Kind of Business/Industry BALTO. CITY		17. Father's Name (First, Middle, Last) JAMES H. JACKSON		18. Mother's Name (First, Middle, Maiden Surname) PERIATTA BOYD	
19a. Informant's Name/Relationship (Type, Print) Barbara Simms / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 EDGEWOOD RD BALTO. MD. 21215		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PK		20c. Location - City or Town, State 8/9/00 Duings Mill	
21. Signature of Funeral Service Licensee James A. Proctor		22. Name and Address of Facility Morton-Sons 1701 LOURDES ST. BALTO MD 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GRAM Negative ROD Septic Shock Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Peripheral Vascular Disease Coronary Artery Disease End stage Renal Disease		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.		29b. Signature and title of certifier James A. Proctor		29c. License number 802 438 946		29d. Date signed (Month, Day, Year) August 04 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASSER ELSOURI 201 E University Pkwy MD 21218	
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature B. Apais		State Registrar					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26222
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur Stuart Jordan				2. Date of Death Month Day Year August 16, 2000		3. Time of Death 3:20 a.m.		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center For Hospice Care				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-05-8434	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 14, 1913	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 8432 D Charles Valley Court			10f. Zip Code 21204-2041		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Indus. Pro. Adm.		16b. Kind of Business/Industry Edgewood Arsenal				
	17. Father's Name (First, Middle, Last) Herbert Robinson Jordan				18. Mother's Name (First, Middle, Maiden Surname) Anna Stuart Green				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Claire J. Cann / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 Hidden Moss Drive Hunt Valley, Maryland 21030				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery		Date 8/21/2000		20c. Location - City or Town, State Owings Mills, Maryland		
	21. Signature of Funeral Service Licenses Earl L. Canapp, CFSP		22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204						
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. renal cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Anthony Riley, MD				29c. License number 025205		29d. Date signed (Month, Day, Year) August 16, 2000			
30. Name and address of person who completed cause of death (other than 23a) (Type, Print) W. A. Riley (GBMC) 6701 N. Charles St. Balto. Md 21208									
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature B. Sparks							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 26223

Amended items# 4a 10a & 18b per FH G786 8-29-00WJJ Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond A. Knott

2. Date of Death

Month Day Year
August 12, 2000

3. Time of Death

7:30 P

4a. Facility Name (If not institution, give street and number)

~~909 Middelbrook Road~~ 909 Meadowbrook Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214.30.7272

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/6/1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

909 Meadowbrook Road

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Sanitary Markets

17. Father's Name (First, Middle, Last)

Leo Knott

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Johnson

19a. Informant's Name/Relationship (Type, Print)

Shirley Knott - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

~~909 Middelbrook Road~~ 909 Meadowbrook Road, Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Cemetery

Date

8/16/00

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee


Kelly Gregory Fink

22. Name and Address of Facility FINK FUNERAL HOME, PA

426 Crain Hwy., SW, Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Colon Cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

20 Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

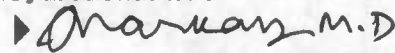
26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier


Dr. Markan M.D.

29c. License number

D39505

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Markan 1600 Crain Hwy, Glen Burnie MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature


Brenda B. Sparks

Baltimore, Maryland 21215-0020

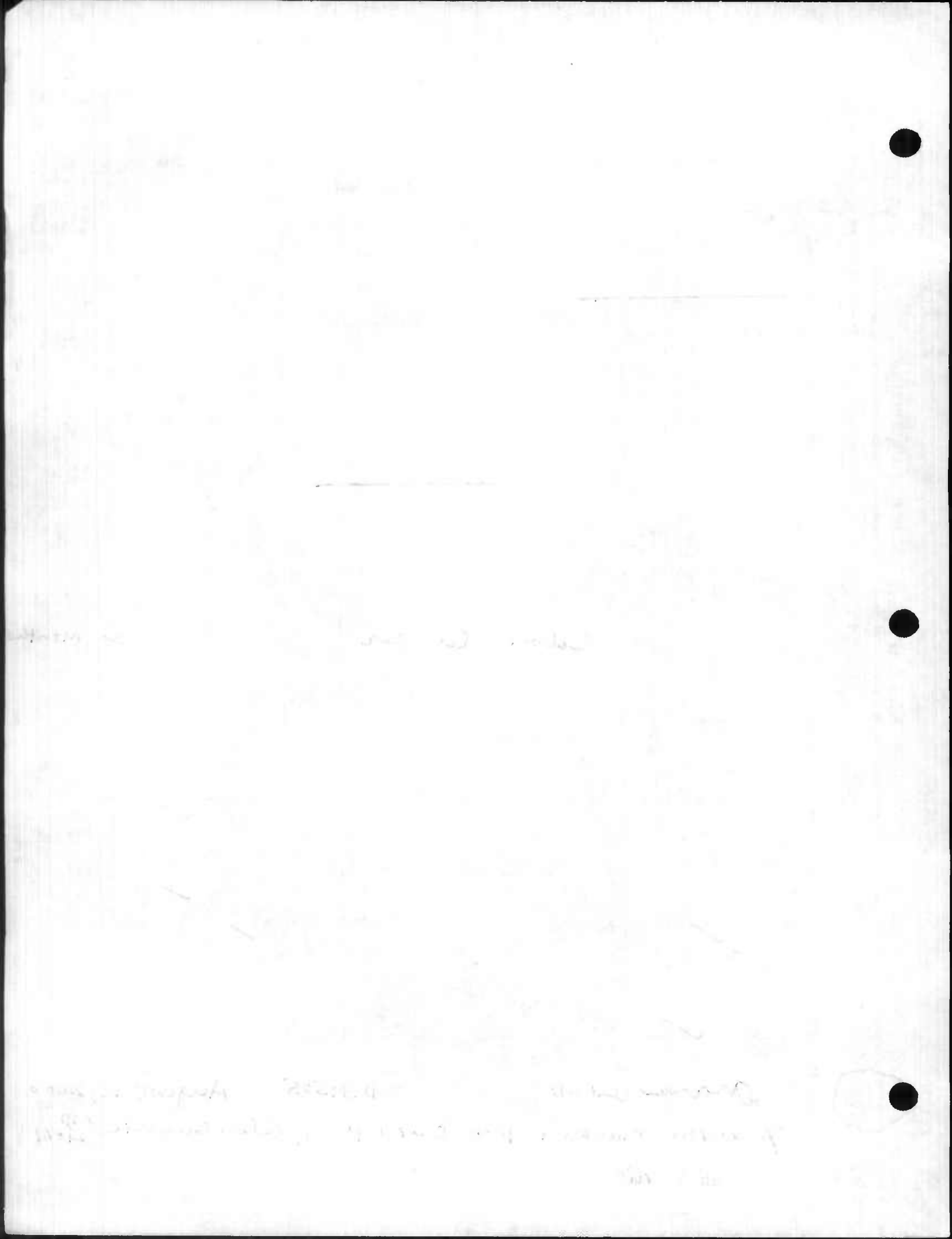
pencil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

00 26224

29d
29d
amend item 29c per phys. G786 8/18/00 yg

Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROOSEVELT KEEMER		2. Date of Death Month August Day 03 Year 2000		3. Time of Death 12,25 am
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital		4b. City, Town, or Location of Death Baltimore, MD		4c. County of Death N/A
Funeral Director	5. Social Security Number 240-12-3607	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 11, 1922		9. Birthplace (State or Foreign Country) N.C.		
To Be Completed by Funeral Director	10a. State md		10b. County N/A		10c. City, Town or Location Baltimore
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1316 WALTERS AVE		10f. Zip Code 21239		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 631 College (1-4or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LOGGER		16b. Kind of Business/Industry SELF EMPLOYED
	17. Father's Name (First, Middle, Last) LESS KEEMER		18. Mother's Name (First, Middle, Maiden Surname) BESSIE CLARK		
	19a. Informant's Name/Relationship (Type, Print) FREDDIE KEEMER/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 WALTERS AVE - BALTO., MD 21239		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CARRISON FOREST VA		20c. Location - City or Town, State 8/8/00 OWINGS MILLS, MD
	21. Signature of Funeral Service Licensee Quynh C. Cormac		22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST - BALTO., MD 21213		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Sepsis with MRSA Due to (or as a consequence of): b. pneumonia with P. aeruginosa Due to (or as a consequence of): c. UTI with E. coli Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CAD, CVA, CRF, HTN, S seizure Parkinson disease					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Sohair Yousef, M.D.					
29c. License number P13133					
29d. Date signed (Month, Day, Year) August 3, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOHAIR YOUSSEF 410. N. ARGONNE AVE Sterling, VA 20164					
31. Date filed (Month, Day, Year) AUG 18 2000					
32. Registrar's Signature Bentley A. Sparks					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26225

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KHAVA

KIPNIS

2. Date of Death

AUG 13 2000

3. Time of Death

9PM

4a. Facility Name (If not Institution, give street and number)

FUTURECARE-CHERRYWOOD NURSING HOME

4b. City, Town, or Location of Death

REISTERSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-35-9466

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

APR. 8 1909

9. Birthplace (State or Foreign Country)

RUSSIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28 BROOKEBURY DRIVE APT. 1-C

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

MAYER

KIPNIS

18. Mother's Name (First, Middle, Maiden Surname)

FAIGA

(UNOBTAINABLE)

19a. Informant's Name/Relationship (Type, Print)

ALEKSANDER SHRAYBMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 BROOKEBURY DR. APT. 1-C REISTERSTOWN, MD. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

8/15/00

20c. Location - City or Town, State

REISTERSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL THROMBOSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

WEEKS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deborah I. Pierce

29c. License number

H45931

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah I. Pierce 7220 PARK HEIGHTS AVE BALTIMORE, MD 21208

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Deborah I. Pierce

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

K HVA KIPNIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26226

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jacqueline Mary Kidd</i>						2. Date of Death Month <i>August</i> Day <i>10</i> Year <i>2000</i>		3. Time of Death <i>11:28 AM</i>												
	4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital</i>						4b. City, Town, or Location of Death <i>Randallstown</i>		4c. County of Death <i>Baltimore</i>												
Funeral Director	5. Social Security Number <i>220-52-3898</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>51</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>8-6-1949</i>		9. Birthplace (State or Foreign Country) <i>MD.</i>												
	Usual Residence of Decedent																				
To Be Completed by Funeral Director	10a. State <i>MD.</i>		10b. County <i>BALTIMORE</i>		10c. City, Town or Location <i>CORTLEIGH</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	10e. Street and Number <i>40 WESTERN WINDS CIRCLE</i>				10f. Zip Code <i>21244</i>		10g. Citizen of What Country? <i>USA</i>														
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>-12-</i> College (14 or 5+) <i>-2-</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HEALTHCARE ADMINISTRATOR</i>			16b. Kind of Business/Industry <i>GOVERNMENT</i>													
	17. Father's Name (First, Middle, Last) <i>JAMES KIDD</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>MARGARET GREEN</i>														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>RYAN GREENE (SON)</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3980 RED DEER CIRCLE RANDALLSTOWN, MARYLAND 21133</i>														
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>DRUID RIDGE CEMETERY</i>		20c. Date <i>8-15-2000</i>		20d. Location - City or Town, State <i>BALTIMORE, MARYLAND</i>												
	21. Signature of Funeral Service Licensee <i>Janeth O. Hines</i>						22. Name and Address of Facility <i>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</i>														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Cardiac arrhythmia</i></td> <td rowspan="4">Approximate interval between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <i>Hemoglobin SC Disease</i></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="2">minutes</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>years</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <i>Cardiac arrhythmia</i>	Approximate interval between Onset and Death	Due to (or as a consequence of):	b. <i>Hemoglobin SC Disease</i>	Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	minutes	Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)	a. <i>Cardiac arrhythmia</i>	Approximate interval between Onset and Death																			
	Due to (or as a consequence of):																				
	b. <i>Hemoglobin SC Disease</i>																				
	Due to (or as a consequence of):																				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	minutes																			
	Due to (or as a consequence of):																				
d.	years																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asthma, hypertension</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred													
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number <i>DV3453</i>		29d. Date signed (Month, Day, Year) <i>August 11, 2000</i>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>V. Dixon King, Jr., MD Northwest Hospital, Randallstown, Maryland.</i>																					
31. Date filed (Month, Day, Year) <i>AUG 18 2000</i>		32. Registrar's Signature <i>[Signature]</i>																			

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26227

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA LINDSEY		2. Date of Death Month August Day 16 Year 2000		3. Time of Death 9:05 PM
	4a. Facility Name (If not institution, give street and number) BAYVIEW MEDICAL CENTER		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-28-4030	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) AUG. 26, 1931		9. Birthplace (State or Foreign Country) MD.		
Usual Residence of Decedent					
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 5200 BOWLEYS LANE, APT. 122			10f. Zip Code 21206		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME
17. Father's Name (First, Middle, Last) HARRY HAMILTON			18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH DELCHER		
19a. Informant's Name/Relationship (Type, Print) BRIAN LINDSEY/SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8048 WYNBROOK RD., BALTIMORE, MD. 21224		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CREST LAWN MEMORIAL		20c. Location - City or Town, State MARRIOTTSTVILLE MARYLAND	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Acute Respiratory Distress Syndrome			Approximate Interval Between Onset and Death 2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Ischemic cardiomyopathy			
		c. Class IV Congestive heart failure			
		d. _____			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Rites Khurana M.D.		29c. License number 21008		29d. Date signed (Month, Day, Year) August 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, Baltimore Maryland 21214					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

Reg. No. 00 26228

ORIGINAL

10/12/1944

10/12/1944

10/12/1944

10/12/1944

10/12/1944

10/12/1944

10/12/1944

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26229

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith A. Leftin

2. Date of Death

August 17, 2000

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Futurecare Cherrywood Health Care

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-20-7074

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

April 8, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

909 Lindellen Avenue

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Operator

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Howard Appeltofft

18. Mother's Name (First, Middle, Maiden Surname)

Freda Schrepfer

19a. Informant's Name/Relationship (Type, Print)

Lynn Kochis (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10228 Harvet Fields Drive, Woodstock, MD 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Druid Ridge Cemetery

Date

8/19/00

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Loring Byers Funeral Directors, Inc.

8728 Liberty Road, Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent Sepsis Episodes

Atherosclerotic Cardiovascular

Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D14753

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert B. Kroppnick, M.D.

4000 Old Court Rd.

Balt, MD 21208

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26230

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NANCY DYER LEONARD		2. Date of Death Month Day Year AUGUST 16, 2000		3. Time of Death 5:40 PM
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 214-01-8036	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) May 8, 1916		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 904 Bellemore Rd.			10f. Zip Code 21210		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Treasure		16b. Kind of Business/Industry Paper Company	
17. Father's Name (First, Middle, Last) ALEXIUS ALOYSIUS DYER			18. Mother's Name (First, Middle, Maiden Surname) TERESA MELANIA BAKER		
19a. Informant's Name/Relationship (Type, Print) Mrs. Nancy Miller (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Bellemore Rd. Baltimore, Maryland 21210		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mausoleum		20c. Location - City or Town, State Timonium, Maryland	
21. Signature of Funeral Service Licensee Robert M. Kratz		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Rd. 21212			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death ONE WEEK					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECENT MYOCARDIAL INFARCTION ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Beatriz P. Dizon M.D.		29c. License number D 16492		29d. Date signed (Month, Day, Year) August 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEATRIZ P. DIZON, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26231

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ida Madeline Litton				2. Date of Death Month Day Year AUGUST 13 2000		3. Time of Death 16:45 PM						
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington						
Funeral Director	5. Social Security Number 215-36-5957		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 16, 1917						
	Usual Residence of Decedent		10a. State PA		10b. County Fulton		10c. City, Town or Location Big Cove Tannery						
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 184 Big Cove Tannery Road		10f. Zip Code 17212		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress				16b. Kind of Business/Industry Clothing Manufacture					
17. Father's Name (First, Middle, Last) Lemuel Shives						18. Mother's Name (First, Middle, Maiden Surname) Eva Pittman							
19a. Informant's Name/Relationship (Type, Print) Madeline C. Booth/Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3288 Tollgate Ridge RD Big Cove Tannery, PA 17212							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Damaucus Cemetery				20c. Location - City or Town, State 8/16/00 Big Cove Tannery, PA					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Chronic pulmonary Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death Weeks year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 						29c. License number 021457			29d. Date signed (Month, Day, Year) 8-13-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL WATHEED, MD - 12821 - OAK HILL AVE. HAGERSTOWN, MD													
31. Date filed (Month, Day, Year) AUG 18 2000						32. Registrar's Signature 							

00 26232

1 - FOR STATE 8/22/00 vs REGISTRAR amend item 1 per phys. G786 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Cardozia McCoy				2. DATE OF DEATH MONTH DAY YEAR August 17 2000		3. TIME OF DEATH 1:15 A M	
4. SOCIAL SECURITY NUMBER 242-26-9903		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 28 1925	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) 1401 East Oliver Street		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1401 East Oliver Street Apartment B6	
10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? U. S. A		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truckman		16b. KIND OF BUSINESS/INDUSTRY Transportation	
17. FATHER'S NAME (First, Middle, Last) John Henry McCoy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Baskins			
19a. INFORMANT'S NAME (Type/Print) Corine Austin/Friend				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 East Oliver Street Apartment B6 MD 21213			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park & Burial		20c. LOCATION — City or Town, State Baltimore County MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Maggaleen Gilmore Herson				22. NAME AND ADDRESS OF FACILITY Mortician 5340 Reisterstown Road Baltimore, Maryland 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Esophagus Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jeffrey J. Pillinger M.D.				29c. LICENSE NUMBER D0053722		29d. DATE SIGNED (Month, Day, Year) Aug 18, 2000	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY J PILLINGER GOOD SAMARITAN HOSP							
31. DATE FILED (Month, Day, Year) AUG 18 2000				32. REGISTRAR'S SIGNATURE Benjamin B. Spack			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26233

AMEND#20B PERF.H. G786 8-18-2000 JAB

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Jane C. Meekins</u>		2. Date of Death Month <u>August</u> Day <u>14</u> Year <u>2000</u>		3. Time of Death <u>5:00 PM</u>
	4a. Facility Name (If not institution, give street and number) <u>Northwest Hospital Center</u>		4b. City, Town, or Location of Death <u>RANDALLSTOWN</u>		4c. County of Death <u>Baltimore County</u>
Funeral Director	5. Social Security Number <u>215-40-2299</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>58</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month <u>JUNE</u> Day <u>15</u> Year <u>1942</u>		9. Birthplace (State or Foreign Country) <u>MD.</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>REISTERSTOWN</u>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <u>76 SHROPSHIRE COURT</u>			10f. Zip Code <u>21136</u>		10g. Citizen of What Country? <u>U.S.A.</u>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>3</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>BAKER</u>		16b. Kind of Business/Industry <u>FOOD</u>	
17. Father's Name (First, Middle, Last) <u>WILLIAM</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>HADEL</u> <u>ANNABELLE</u> <u>(UNKNOWN)</u>		
19a. Informant's Name/Relationship (Type, Print) <u>CAROLE MEEKINS/ DAUGHTER</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4602 OWINGS RUN ROAD APT. 101 OWINGS MILLS, MD. 21117</u>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>LAKEVIEW MEMORIAL PARK</u>		20c. Location - City or Town, State <u>ELDERSBURG, MD.</u>	
21. Signature of Funeral Service Licensee <u>Jay Alan Lewis</u>		22. Name and Address of Facility <u>SOL LEVINSON & BROS. INC.</u> <u>B900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Intracerebral Hemorrhage</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>J Boston MD</u>		29c. License number <u>D28462</u>		29d. Date signed (Month, Day, Year) <u>August 14, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>J Boston Northwest Hospital Center Randallstown Maryland</u>					
31. Date filed (Month, Day, Year) <u>AUG 18 2000</u>		32. Registrar's Signature <u>Bennett B Sparks</u>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26234

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris V. McQuaige

2. Date of Death

Month

Day

Year

August 14 2000

3. Time of Death

2115

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

214-44-5245

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6/18/47

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2107 Summit Ave.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

B.A. Degree

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

City Auditor

16b. Kind of Business/Industry

City of Baltimore

17. Father's Name (First, Middle, Last)

James Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Violet Johnson

19a. Informant's Name/Relationship (Type, Print)

Lisa McQuaige

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

824 Shipfriend Rd., Baltimore, Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Mem. Pk.

Date

8/21/00 Randallstown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Md. 21202
March F.H. East 1101 E. North Ave.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ovarian Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carlos Bagley, MD Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Patient known as Doris McQuaige
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26235

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lorraine McClary

2. Date of Death

August 11, 2000

3. Time of Death

9:45am

4a. Facility Name (If not institution, give street and number)

1718 E. 31st Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-34-7794

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

July 25, 1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1718 E. 31st Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

state

17. Father's Name (First, Middle, Last)

Cleveland McClary

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Cur

19a. Informant's Name/Relationship (Type, Print)

Maureen Dunlap

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1201 Darley Ave. Baltimore, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

8/16/00

20c. Location - City or Town, State

Lansdowne, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Willy's Funeral Home PA
658 N. Calverton St. Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal failure

Due to (or as a consequence of):

b. Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol Abuse

Anemia

Degenerative disc disease spine

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D30717

29d. Date signed (Month, Day, Year)

08/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alicia A Cool MD 6701 N Charles St Ste 3901 Balt MD 21204

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26236

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Laraine J. Mc Kinley

2. Date of Death

August 15 2000

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-42-5404

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 3, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Dodworth Court Apt 104

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

5+

18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Herbert Mc Kinley

18. Mother's Name (First, Middle, Maiden Surname)

Helen M. Brown

19e. Informant's Name/Relationship (Type, Print)

Susan Shugars Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

271 W. 31st Street, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Moreland Memorial Park

Date

8/19/00

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Lynn B. Henss

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Hypertensive Arteriosclerotic

Due to (or as a consequence of):

b. Cardio Renal Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicida4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles F. O'Donnell MD

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD

117 Hamlet Hill Rd
Baltimore 21210

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26237

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles W Mauerhan		2. Date of Death Month Day Year August 13, 2000		3. Time of Death 10:08 PM
	4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation and Extended Care		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City
Funeral Director	5. Social Security Number 212 07 0241	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91	8. Date of Birth (Month, Day, Year) March 6 1909	9. Birthplace (State or Foreign Country) Baltimore, Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore County		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 4304 Necker Avenue		10f. Zip Code 21236		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Letter Carrier
	16b. Kind of Business/Industry US Postal Service		17. Father's Name (First, Middle, Last) Charles Frederick Mauerhan		18. Mother's Name (First, Middle, Maiden Surname) Edna Hahn
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helen Mauerhan (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4304 Necker Avenue Baltimore, Maryland 21236		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. August 16, 2000		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee Walter Joseph Chamocki		22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death 1 year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, chronic renal insufficiency		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Ray L. Collins		29c. License number D0032548		29d. Date signed (Month, Day, Year) August 14, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERRY L COLLINS 10 North Greene Street Baltimore, Maryland					
State Registrar	31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature Benjamin S. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26238

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joseph Myers</i>				2. Date of Death Month <i>08</i> Day <i>15</i> Year <i>00</i>			3. Time of Death <i>1600</i>		
	4a. Facility Name (If not institution, give street and number) <i>Shock Trauma Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death		
Funeral Director	5. Social Security Number <i>220-12-3071</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>78</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec. 12, 1921</i>		9. Birthplace (State or Foreign Country) <i>Virginia</i>	
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <i>Maryland</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Annapolis</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>2319 Hickory Road</i>				10f. Zip Code <i>21401</i>		10g. Citizen of What Country? <i>United States</i>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>6th</i> <i>College (1-4or 5+)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Rigger</i>			16b. Kind of Business/Industry <i>US Government</i>			
17. Father's Name (First, Middle, Last) <i>Charles G. Myers</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Minnie M. Duncan</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Hilda Whittington/Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>717 Appomattox Rd. Davidsonville, MD 21035</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Oak Grove Church Cemetery</i>		Date <i>8/19</i>		20c. Location - City or Town, State <i>Aylor, Virginia</i>				
21. Signature of Funeral Service Licensee <i>Batrick J. Brown</i>				22. Name and Address of Facility <i>Hardesty Funeral Home, P.A. 12 Ridgely Avenue Annapolis, MD 21401</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Pneumonia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate Interval Between Onset and Death <i>2 weeks</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> <i>Congestive Heart Failure</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Kerry Kole DO</i>		29c. License number <i>H55103</i>		29d. Date signed (Month, Day, Year) <i>Aug 15 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kerry Kole, 22 South Greene Street, Baltimore, Maryland 21201</i>										
31. Date filed (Month, Day, Year) <i>AUG 18 2000</i>		32. Registrar's Signature <i>Benny A. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26239

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Adeline H. Merritt</i>				2. Date of Death Month <i>August</i> Day <i>13</i> Year <i>2000</i>				3. Time of Death <i>6:30 a.m.</i>						
	4a. Facility Name (If not institution, give street and number) <i>2009 Ruxton Avenue</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>						
Funeral Director	5. Social Security Number <i>214-18-9961A</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>91</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <i>Dec. 15, 1908 Pa.</i>		9. Birthplace (State or Foreign Country)		
	Usual Residence of Decedent														
10a. State <i>Md.</i>		10b. County <i>n/a</i>		10c. City, Town or Location <i>Baltimore</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>2009 Ruxton Road</i>						10f. Zip Code <i>21216</i>				10g. Citizen of What Country? <i>USA</i>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th Grade</i> College (1-4 or 5+) <i>Charlady</i>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Charlady</i>				16b. Kind of Business/Industry <i>Baltimore Gas & Electric Co.</i>					
17. Father's Name (First, Middle, Last) <i>John Showell</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Edith Turpin</i>									
19a. Informant's Name/Relationship (Type, Print) <i>Sedonia R. Merritt Daughter</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2009 Ruxton Avenue Baltimore, Md. 21216</i>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial Park</i>				Date <i>Aug. 17</i>		20c. Location - City or Town, State <i>Baltimore, Md.</i>					
21. Signature of Funeral Service Licensee <i>Herbert E. Nutter</i>						22. Name and Address of Facility <i>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</i>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>MYOCARDIAL INFARCTION</i> Due to (or as a consequence of): <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death <i>1 Hour</i>															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i> <i>Hypertension</i>															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>430408</i>				29d. Date signed (Month, Day, Year) <i>8/15/00</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Paul A. Winston md 3100 Towanda Ave Baltimore md</i>															
31. Date filed (Month, Day, Year) <i>AUG 18 2000</i>				32. Registrar's Signature <i>[Signature]</i>											

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: # 23 PART I, II, 27, 28A-F PER MEO G787

Certificate of Death

9-6-00 WR00 26240

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) James A. Outten		2. Date of Death Month August Day 15 Year 2000		3. Time of Death 1815 pm	
4a. Facility Name (If not institution, give street and number) 3605 Southern Avenue			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 215-52-4964	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 26, 1951
9. Birthplace (State or Foreign Country) Md.		Usual Residence of Decedent			
10a. State Md.	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3605 Southern Ave.			10f. Zip Code 21214		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) 2 yrs.			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry Pastry			
17. Father's Name (First, Middle, Last) Walter Outten			18. Mother's Name (First, Middle, Maiden Surname) Maxine Cross		
19a. Informant's Name/Relationship (Type, Print) Susan Outten wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 Southern Ave. Baltimore Md. 21214		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Baltimore	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Connolly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE NARCOTIC INTOXICATION					Approximate Interval Between Onset and Death
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC PAIN					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8-15-00		28b. Time of Injury Found: 6:00 PM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3605 SOUTHERN AVE. BALTIMORE CITY, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26241

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERNON PINKETT		2. Date of Death Month August Day 15 Year 2000		3. Time of Death 5:19 AM
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 214-34-4202	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) MAY 16, 1936		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MARYLAND		10b. County N/A
	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 303 NORTH CAREY		10f. Zip Code 21223		10g. Citizen of What Country? USA.
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8+HIGHER College (1-4 or 5+) College		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MEAT CUTTER		16b. Kind of Business/Industry HOTEL SUPPLIER		
	17. Father's Name (First, Middle, Last) EDWARD PINKETT		18. Mother's Name (First, Middle, Maiden Surname) NANCY DOUGLASS		
	19a. Informant's Name/Relationship (Type, Print) ROBIN YORKER (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 N. CAREY ST., BALTIMORE, MD. 21223		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 8-19-00 LANSDOWNE, MARYLAND
	21. Signature of Funeral Service Licensee JOSEPH H. BROWN JR.		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) End-stage AIDS					2 months
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure pneumonia					
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
24a. Was an autopsy performed? 1 Yes 2 No					24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier E. S. FEEN			
29c. License number AT2438946-A2		29d. Date signed (Month, Day, Year) August 15, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL, DEPT. OF MEDICINE, 201 E. PARKWAY, MD 21218					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26242

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Person				2. Date of Death Month August Day 13 Year 2000		3. Time of Death 3:21 AM			
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA			
Funeral Director	5. Social Security Number 214-22-8837		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) February 23, 1926			
	9. Birthplace (State or Foreign Country) VA		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4404 Belle Ave		10f. Zip Code 21207		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesclerk		16b. Kind of Business/Industry Retail					
	17. Father's Name (First, Middle, Last) Standhope Harvey				18. Mother's Name (First, Middle, Maiden Surname) Lillian Sara Harvey					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thurman Person Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4404 Belle Ave. Baltimore, MD 21207					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State 8/18/00 Owings Mills, MD		22. Name and Address of Facility Wyle Funeral Home PA 21217 1038 N. Belmor St. Baltimore, MD			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL infarction / CARDIAC ARREST Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. DIABETES Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Wallace John L. (John L.)				29c. License number D38086		29d. Date signed (Month, Day, Year) August 16, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4510 Liberty Heights Ave Balto Md 21207									
	31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature Benjamin B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26243

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Barbara Peterka

2. Date of Death

August 12, 2000

3. Time of Death

10:30pm

4a. Facility Name (If not institution, give street and number)

ASBURY HOME

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery County

Funeral
Director

5. Social Security Number

218-01-6259

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 1, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery County

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

403 Russell Avenue, Apt 607

10f. Zip Code

20877

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal
Internal Revenue Serv.

17. Father's Name (First, Middle, Last)

Vincent

18. Mother's Name (First, Middle, Maiden Surname)

Suchanek

Barbara

Vlna

19a. Informant's Name/Relationship (Type, Print)

Janet E. Scaggs (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15133 Middlegate Road, Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

8/23/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

b. HYPERTENSIVE HEART DISEASE

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression, Arthritis, Gastro-esophageal Reflux,

Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician:2 ☐ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Priscilla Callahan-Lyon, M.D.

29c. License number

041794

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Priscilla Callahan-Lyon, M.D., 911 Russell Ave., Gaithersburg, MD 20879

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26244

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Homer Martin Pennington

2. Date of Death

August 17 2000

3. Time of Death

1:55 PM

4a. Facility Name (If not institution, give street and number)

11 Maryland Avenue

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

236-34-3636

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 22 1926

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11 Maryland Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

U.S. of America

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lieutenant Fire Fighter

16b. Kind of Business/Industry

Fire Department

17. Father's Name (First, Middle, Last)

Homer

Pennington

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy

Harvey

19a. Informant's Name/Relationship (Type, Print)

Sophia Pennington (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Maryland Avenue Dundalk, Maryland 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn

Date

August 21

20c. Location - City or Town, State

Eastpoint, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

W. Dabrowski-Chojnacki F.H.'s P.A.

1005 Dundalk Ave. Baltimore, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Congestive Heart Failure

Valvular Heart Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40609

29d. Date signed (Month, Day, Year)

August 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1792 Merritt Blvd Balto - MD 21222

31. Date of Death (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

33. Registrar's Title

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26245

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) CHARLES POWELL						2. Date of Death Month 8 Day 14 Year 2000		3. Time of Death 1245PM	
4e. Facility Name (If not institution, give street and number) 821 N EUTAW ST. SUITE 305						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
5. Social Security Number 243-20-1606		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 12-5-1921		9. Birthplace (State or Foreign Country) N.C.	
Usual Residence of Decedent									
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 911 ALLENDALE ST.				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FORK LIFT OPERATOR			16b. Kind of Business/Industry CURTIS BAY ORDNANCE DEPT.		
17. Father's Name (First, Middle, Last) UNKNOWN						18. Mother's Name (First, Middle, Maiden Surname) GEORGIANA POWELL			
19a. Informant's Name/Relationship (Type, Print) GERTRUDE POWELL (SPOUSE)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 ALLENDALE ST BALTIMORE MD 21229			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATL. CEM 8-18-00 BALTIMORE MD		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee EUGENE WALKER				22. Name and Address of Facility ESTEP BROS. FUNERAL SERV. 1300 EUTAW PLACE BALTO. MD 21217					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PHYSICIAN'S OFFICE							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier [Signature]				29c. License number 529071		29d. Date signed (Month, Day, Year) 8/14/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANANDA KRISHNAN 821 N. EUTAW ST # 305 BALTIMORE MD 21201									
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature [Signature]					

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26246

amend item 3 per phys. G786 8/31/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Darinka Papich						2. Date of Death Month Day Year August 16, 2000		3. Time of Death Am PM 9:40 PM													
	4a. Facility Name (If not institution, give street and number) St. Elizabeth's Nursing Home						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A													
Funeral Director	5. Social Security Number 295-18-8414		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80		8. Date of Birth (Month, Day, Year) JAN 11, 1920		9. Birthplace (State or Foreign Country) Ohio													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 16 Wade Avenue						10f. Zip Code 21228		10g. Citizen of What Country? USA														
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Agent		16b. Kind of Business/Industry Hotel & Restaurant Workers Union														
17. Father's Name (First, Middle, Last) Radoslav Papich						18. Mother's Name (First, Middle, Maiden Surname) Stana Radosavkitch																
19a. Informant's Name/Relationship (Type, Print) Nevena Whitaker/Sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Wade Avenue Catonsville, MD 21228																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 8-21-00		20c. Location - City or Town, State Baltimore, MD															
21. Signature of Funeral Service Licenses Edward A. Gregorich						22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Metastatic Gastric CA to Liver</td> <td>6 mos.</td> </tr> <tr> <td>b.</td> <td>Gastric Cancer</td> <td>9 mos.</td> </tr> <tr> <td>c.</td> <td>Hypertension</td> <td>20 yr</td> </tr> <tr> <td>d.</td> <td>Peripherical Vascular Disease</td> <td>20 yr.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic Gastric CA to Liver	6 mos.	b.	Gastric Cancer	9 mos.	c.	Hypertension	20 yr	d.	Peripherical Vascular Disease	20 yr.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic Gastric CA to Liver	6 mos.																			
	b.	Gastric Cancer	9 mos.																			
	c.	Hypertension	20 yr																			
	d.	Peripherical Vascular Disease	20 yr.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypo thyroidism Osteoporosis																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred													
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier William Reilly MD						29c. License number D54749		29d. Date signed (Month, Day, Year) August 17, 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 Business Center Drive, Reisterstown, MD 21134																						
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature B. Sparks																				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Page 12

The first of the three
is the one which is
the most common
and is the one which
is the most common

The second of the three
is the one which is
the most common
and is the one which
is the most common

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26247

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VESTON RAY RAWLS

2. Date of Death

August 16, 2000

3. Time of Death

6:44am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

AA COUNTY

5. Social Security Number

224-50-6352

6. Sex

XX

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9/23/1940

9. Birthplace (State or Foreign Country)

S. Norfolk, VA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

692 Winding Stream Way

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No 1958-
If Yes, Give
Year or Dates: 1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Inspector - Elevators

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Henry Rawls

18. Mother's Name (First, Middle, Maiden Surname)

Thelma E. Browney

19a. Informant's Name/Relationship (Type, Print)

Rosemary A. Rawls - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

692 Winding Stream Way, Odenton, MD 21113

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bayview Crematory

Date

8/18

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Kelly Gregory Fink

22. Name and Address of Facility

FINK FUNERAL HOME, PA

426 Crain Hwy., SW, Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Oligospondylar Cerebellar Degeneration

Due to (or as a consequence of):

5 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D50108

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Downing, MD 7845 Oakwood Road, Suite 201, Glen Burnie, MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

RAWLS VESTON R.
Baltimore, Maryland 21215-0020Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26248

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur Randolph				2. Date of Death Month Aug Day 13 Year 2000		3. Time of Death 8:30am	
	4a. Facility Name (If not institution, give street and number) Blue Point Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 217-40-0410		6. Sex XXM 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) 03 04 40	
	9. Birthplace (State or Foreign Country) M.D.		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2525 West Belvedere Ave		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+) na		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crain Operator		16b. Kind of Business/Industry H. Reaff & Company		17. Father's Name (First, Middle, Last) John Randolph Sr.		
18. Mother's Name (First, Middle, Maiden Surname) Dorothy M. Smith		19a. Informant's Name/Relationship (Type, Print) Dorothy M. Randolph-Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5410 Lynview Ave, Baltimore Md 21215		20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State Baltimore, Md		21. Signature of Funeral Service Licensee John A. Thompson		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Rectal Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure Disorder Renal failure Prostate Cancer				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				
28a. Date of injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Shalini Tewari MD				29c. License number D52671		29d. Date signed (Month, Day, Year) August 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Tewari MD 1838 Greene Tree Rd/Suite 300/Pikesville, MD 21208				31. Date filed (Month, Day, Year) AUG 18 2000				
32. Registrar's Signature Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26249

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWIN JOSEPH RENSCHAW

2. Date of Death

August 17, 2000

3. Time of Death

0630

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER-STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-38-3827

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

SEPT. 27, 1941

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
ANNE ARUNDEL10c. City, Town or Location
GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6506 HOME WATER WAY, SUITE 104

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☐ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

FRANCIS

RENSCHAW

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED

DUDY

19a. Informant's Name/Relationship (Type, Print)

MRS. MARY RENSCHAW (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6506 HOME WATER WAY, SUITE 104, GLEN BURNIE, MD. 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD.

Date

8/20/2000

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Metastatic Pancreatic Carcinoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

9 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-07930

29d. Date signed (Month, Day, Year)

August 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mercy Medical Ctr 301 St Paul Pl #407 Towee Bldg MD 21202

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26250

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUNICE SCHRAMM ROMING						2. Date of Death Month Day Year August 16, 2000		3. Time of Death 3:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 108 Brightwood Club Drive						4b. City, Town, or Location of Death Lutherville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-10-6232		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) July 5, 1908		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville				10d. Inside City Limits 1 Yes 2 No		
10e. Street and Number 108 Brightwood Club Drive						10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Henry Schramm						18. Mother's Name (First, Middle, Maiden Surname) Margaret Meehan				
19a. Informant's Name/Relationship (Type, Print) Carl Schramm (nephew)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Gracefield Road Apt. 624 Silver Spring, MD 20904				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 8-17-00		
21. Signature of Funeral Service Licensee George J. Fername						22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Cardiomyopathy Due to (or as a consequence of): b. Congestive heart failure Due to (or as a consequence of): c. Atrial fibrillation Due to (or as a consequence of): d.										
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
24a. Was an autopsy performed? 1 Yes 2 No										
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease Hypertension										
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				28a. Date of Injury (Month, Day Year) 8/17/00		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 Medical Examiner						
29b. Signature and title of certifier Laura M. Mumford, M.D.				29c. License number D 18410				29d. Date signed (Month, Day, Year) 8/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laura M. Mumford, M.D. 10755 Falls Road Suite 470 Lutherville, MD 21093										
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26251
3. Time of Death
AUGUST 12, 2000 6:45 PM

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry F Ross

2. Date of Death

Month Day Year
AUGUST 12, 2000

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218 03 0322

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 25, 1916

9. Birthplace (State or Foreign Country)

Baltimore Co., MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4216 Klosterman Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Black & Decker Corp.

17. Father's Name (First, Middle, Last)

Joseph Ross

18. Mother's Name (First, Middle, Maiden Surname)

Willmina Klosterman

19a. Informant's Name/Relationship (Type, Print)

Margaret M Ross (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4216 Klosterman Avenue Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. August 16, 2000

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Reatha Ross

22. Name and Address of Facility

Lassahn Funeral Home Inc
7401 Belair Road Baltimore, Maryland 21236

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death

UNKNOWN

Due to (or as a consequence of):

b. HEMOPTYSIS

1-2 HRS

Due to (or as a consequence of):

c. HEMATEMESIS RESPIRATORY DIFFICULTY

15 HOURS

Due to (or as a consequence of):

d. GASTRIC TUMOR

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION; POSSIBLE AORTIC ARCH ANEURYSM

VILLOUS ADENOMA CECUM RIGHT HEMI-COLECTOMY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Eduardo P. Layug M.D.

29c. License number

D 24025

29d. Date signed (Month, Day, Year)

08/12/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EDUARDO P. LAYUG, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26252

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE RICHARDS				2. Date of Death Month 8 Day 15 Year 00		3. Time of Death 1:09 AM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND/SHOCK TRAUMA				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 218-14-8024		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) April 27, 1923	
	9. Birthplace (State or Foreign Country) Ga.		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7114 Minna Road		10f. Zip Code 21244		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tinning Operator		16b. Kind of Business/Industry Bethlehem Steel		
17. Father's Name (First, Middle, Last) George Richards		18. Mother's Name (First, Middle, Maiden Surname) Annie L. Rucker		19a. Informant's Name/Relationship (Type, Print) Patricia Diggs daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7114 Minna Road Baltimore, Md. 21244		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date Aug. 19		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee Honest R. Perry, Jr.		22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. SUBDURAL HEMATOMA Due to (or as a consequence of): b. MYOCARDIAL INFARCTION Due to (or as a consequence of): c. SEPSIS Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CERTIFICATION APPROVED BY MEDICAL EXAMINER		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7 31 00		
28b. Time of Injury UNK M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Fall down steps		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME		
28f. Location (Street and Number or Rural Route Number, City or Town, State) 7114 MINNA RD 21207		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Michael S. Howard		29c. License number 1196		
29d. Date signed (Month, Day, Year) 8/15/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Baltimore, MD 21201		31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature B. Sparks		

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26253

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM C. SMITH

2. Date of Death

Month
Day
Year

AUG 14 2000

3. Time of Death

06-05 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care of Catonsville

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-12-1058

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-24-17

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

98 Smithwood Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1941-
195213. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
unknownCollege (1-4 or 5+)
unknown16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chauffeur

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

John Henry SMITH

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Johnson

19a. Informant's Name/Relationship (Type, Print)

Mariner Health Care of Catons.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

98 Smithwood Avenue, Baltimore, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Metastatic carcinoma

Due to (or as a consequence of):

b. carcinoma of Prostate

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 yr

4 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

stroke

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Baskaran

29c. License number

D 21649

29d. Date signed (Month, Day, Year)

Aug 16, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SANTANIO BASKARAN, 3457 Wilkens Ave. Baltimore, MD 21229

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Geneva B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26254

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KURT SUMMERS

2. Date of Death

Month Day Year
August 4, 2000

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

CASEY HOUSE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

208-26-3588

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 22, 1934 PA

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2713 Rambler Place

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 2/53-

11/56

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Wilbur Orville Summers

18. Mother's Name (First, Middle, Maiden Sumema)

Bertha Mae Clinton

19a. Informant's Name/Relationship (Type, Print)

Kathryn M. Stroud/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9895 Otis Court, Westminster, CO 80021-5435

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Squamous Cell Carcinoma 5 yrs.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK S. BODEK M.D. CASEY HOUSE

6001 MUMFORD MILL RD
ROCKVILLE, MD 20855State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Benita B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26255

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH SHEARILL		2. Date of Death Month: AUGUST Day: 15 Year: 2000		3. Time of Death 4:10 A.M.
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-24-8457	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) NOV. 07, 1918		9. Birthplace (State or Foreign Country) SOUTH CAROLINA		
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10a. Street and Number 2501 VIOLET AVE, APT #911		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 6TH GRADE College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS	
16b. Kind of Business/Industry WYLIE MANUFACTURING CO.		17. Father's Name (First, Middle, Last) BILLY WILLIAMS		18. Mother's Name (First, Middle, Maiden Surname) MARIE YOUNG BLOOD	
19a. Informant's Name/Relationship (Type, Print) ARTHUR WILLIAMS (BROTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 VIOLET AVE, APT #911, BALTIMORE, MD 21215			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		20c. Location - City or Town, State 8-21-00 CATONSVILLE, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR, FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SUPERIOR MESENTERIC ARTERY THROMBOSIS Due to (or as a consequence of): b. NECROTIC BOWEL Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Anthony Anton, MD		29c. License number 57117	
29d. Date signed (Month, Day, Year) AUGUST, 15, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL 2401 W. BELVEDERE AVE., BALTIMORE, MARYLAND 21215			
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26256

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAX SUGAR		2. Date of Death Month Day Year AUGUST 15, 2000		3. Time of Death 8:30 PM						
	4a. Facility Name (If not institution, give street and number) 2510 HAL CIRCLE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE						
Funeral Director	5. Social Security Number 112-26-5657	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hour Min.						
	8. Date of Birth (Month, Day, Year) MAY 5, 1917		9. Birthplace (State or Foreign Country) POLAND								
Usual Residence of Decedent											
10a. State NY		10b. County		10c. City, Town or Location CEDARHURST							
10e. Street and Number 46 CEDARHURST AVENUE		10f. Zip Code 11516		10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:							
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER							
16b. Kind of Business/Industry WOOD WORKING		17. Father's Name (First, Middle, Last) JOEL SUGAR		18. Mother's Name (First, Middle, Maiden Surname) SHIFRA (UNKNOWN)							
19a. Informant's Name/Relationship (Type, Print) HYMAN SUGAR / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2510 HAL CIRCLE, BALTIMORE, MD 21209									
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH MOSES		20c. Location - City or Town, State 8/16/00 PINELAWN, NEW YORK							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Sepsis</td> <td rowspan="4"> Approximate Interval Between Onset and Death 2 day 3 months </td> </tr> <tr> <td>b. MENINGITIS and PNEUMONIA</td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis	Approximate Interval Between Onset and Death 2 day 3 months	b. MENINGITIS and PNEUMONIA	c.	d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis	Approximate Interval Between Onset and Death 2 day 3 months									
	b. MENINGITIS and PNEUMONIA										
	c.										
	d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malignant meningioma											
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown											
24a. Was an autopsy performed? 1 Yes 2 No											
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No											
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SON'S RESIDENCE									
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M							
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 		29c. License number 025039		29d. Date signed (Month, Day, Year) 8/17/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JULIAN JANKOVIC, MD 1835 Smith Ave BALT MD 21209											
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #17 PER F.H. G786 8-18-2000 JAB

Certificate of Death

Reg. No.

00 26257

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIA

SILBERKWEIT

2. Date of Death

August 11, 2000

3. Time of Death

8:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Ctr. Hospice Randallstown, MD

4b. City, Town, or Location of Death

4c. County of Death

Baltimore Co.

5. Social Security Number

577-44-9071

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

8. Date of Birth

JULY 1 1904

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3204 OLD POST DRIVE # 12

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (13-16)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DENTIST

16b. Kind of Business/Industry

DENTISTRY

17. Father's Name (First, Middle, Last)

DR. SOLOMON SILBERKWEIT

18. Mother's Name (First, Middle, Maiden Surname)

NECHAMA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

GALA STERN/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3605 ANTON FARMS ROAD BALTIMORE, MD. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON-CHIZUK AMUNO CONGREGATION

Date

8/14/00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician 2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44505

29d. Date signed (Month, Day, Year)

8/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN IMPERIAL, JR. MWGK

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at 202-261-2222.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

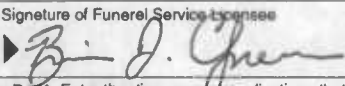

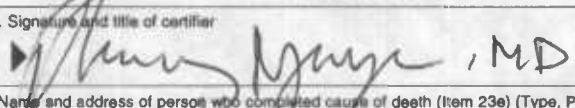
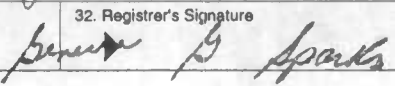
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26258

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT SAWYER SR.				2. Date of Death Month 8 Day 16 Year 00		3. Time of Death 9:19 PM	
	4a. Facility Name (If not institution, give street and number) BAYVIEW BURN MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 244-20-1214	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOV. 15, 1925		9. Birthplace (State or Foreign Country) NC
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location MILLERSVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 331 POPLAR ROAD				10f. Zip Code 21108		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUILDER			16b. Kind of Business/Industry CONSTRUCTION	
17. Father's Name (First, Middle, Last) ROBERT W. SAWYER				18. Mother's Name (First, Middle, Maiden Surname) ALETHIA C. CLIFTON				
19a. Informant's Name/Relationship (Type, Print) MRS. ELLEN UPMAN (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 LISMORE LANE, BALTIMORE, MD. 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		20c. Location - City or Town, State GLEN BURNIE, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Complications of thermal injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7/11/00		28b. Time of Injury 1914 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was victim of propane gas explosion of house
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 331 POPLAR RD, MILLERSVILLE, MD				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.				29c. License number KES-000		29d. Date signed (Month, Day, Year) 8/16/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PHUONG NGUYEN 11 S. Eutaw St. #1208 BALTIMORE, MD 21201								
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26259

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Anne Steinnagel

2. Date of Death

Month Day Year

August 16, 2000

3. Time of Death

8:41 AM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-28-3472

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 30, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5740 Oklahoma Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Regon Life Ins. Company

17. Father's Name (First, Middle, Last)

Frank Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Lee Carl

19a. Informant's Name/Relationship (Type, Print)

Erich Steinnagel (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2061 Conan Doyle Way, Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Cemetery

Date

8/19/00

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.
8728 Liberty Road, Randallstown, Maryland 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

024970

29d. Date signed (Month, Day, Year)

AUGUST 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLIFFORD FABER, MD 5401 OLD COURT RD RANDALLSTOWN, MARYLAND 21133

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26260

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Schwartz						2. Date of Death Month Day Year August 17 2000		3. Time of Death 5:20 am		
	4a. Facility Name (If not institution, give street and number) Sunrise Assisted Living						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 213-74-4415		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) March 12, 1906		9. Birthplace (State or Foreign Country) Romania		
	Usual Residence of Decedent										
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 468 Riverview Drive				10f. Zip Code 21037		10g. Citizen of What Country? Romania					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None College (1-4 or 5+) None				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Nusson Ziets						18. Mother's Name (First, Middle, Maiden Surname) Chaika Cogan					
19a. Informant's Name/Relationship (Type, Print) Barbara Seidel (Daughter)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 468 Riverview Drive, Edgewater, MD 21037					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem. Gardens		Date 08/19 2000		20c. Location - City or Town, State Falls Church, VA			
21. Signature of Funeral Service Licensee <i>Barbara Seidel</i>						22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>pneumonia</i> Due to (or as a consequence of): b. <i>congestive heart failure</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death days weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Merkel Cell Carcinoma</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Assisted Living</i>									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number D41955		29d. Date signed (Month, Day, Year) 8-17-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Rebecca Thompson 479 Jumper Hole Rd Severna Park MD 21146</i>											
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26261

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Rose Smith				2. Date of Death Month Aug. Day 17 Year 2000		3. Time of Death 7:00 a.m.	
	4a. Facility Name (If not institution, give street and number) Summerville at Westminster				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-60-6353		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 8, 1906	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Marriottsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7065 Ridge Rd.		10f. Zip Code 21104	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Homemaker		17. Father's Name (First, Middle, Last) Edward H. Frailer	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Lena Schroth				19a. Informant's Name/Relationship (Type, Print) Beverly Dannelly - daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7065 Ridge Rd. Marriottsville, Md. 21104	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kriders Church Cem. Aug. 19, 2000		20c. Location - City or Town, State Westminster, Md.		21. Signature of Funeral Service Licensee J. Smith Eckhardt	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Advanced age Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 6 hrs 25 yr 95 yr	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred Living				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. Smith Eckhardt		29c. License number D25443	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 8/17/2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton 688 Poble Rd Westminster Md 21157			
	31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature B. Sparks			

ORIGINAL

10. 10. 1944

General

of 1944

Washington

General

1944

1944

General

General

General

General

General

General

General

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26262

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jamie Lynn Spealman		2. Date of Death Month Day Year AUGUST 16 2000		3. Time of Death 0353	
	4a. Facility Name (If not institution, give street and number) MARYLAND SHOCK TRAUMA		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 212-17-7642	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 17 Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 14, 1982	9. Birthplace (State or Foreign Country) Hanover, Pa.
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State Md.	10b. County Carroll	10c. City, Town or Location Hampstead		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3120 Main Street Apt. 5		10f. Zip Code 21074		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cert. Nursing Assistant		16b. Kind of Business/Industry Nursing Home	
	17. Father's Name (First, Middle, Last) William S. Black Jr.		18. Mother's Name (First, Middle, Maiden Surname) Billie Jean Spealman			
	19a. Informant's Name/Relationship (Type, Print) William S. Black Jr. - father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4115 Creswell Tr. Hampstead, Md. 21074			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Lutheran Cem.		20c. Location - City or Town, State Aug. 19, 2000 Manchester, Md.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 8/13/00		28b. Time of Injury 6:30 AM		
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver involved in motor vehicle accident		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 30/5, Balser Road Manchester, MD		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUGUST 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26263

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara J. Smyth				2. Date of Death Month Day Year AUGUST 15, 2000		3. Time of Death 10:05PM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 040-05-6746		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 1-21-1918	
	9. Birthplace (State or Foreign Country) Connecticut		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1055 W. Joppa Road		10f. Zip Code 21204		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Agent		16b. Kind of Business/Industry Westinghouse			
	17. Father's Name (First, Middle, Last) Leroy Ernest Joyce				18. Mother's Name (First, Middle, Maiden Surname) Ethel Barrett			
	19a. Informant's Name/Relationship (Type, Print) Mr. Wilbur C. Jensen (Attorney)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 W. Pennsylvania Ave., Towson, Maryland 21204			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gards. 8-21-00 Timonium, Maryland		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr.				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPSIS RENAL FAILURE							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier A. J. Helou, M.D.		29c. License number D17695	
	29d. Date signed (Month, Day, Year) August 15, 2000							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELOU, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204							
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature [Signature]				

ORIGINAL

Dean Topolski

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEOCG786 8-19-00 WR

Reg. No.

00 26264

Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dean Gilbert Topolski		2. Date of Death Month Day Year August 09 2000		3. Time of Death 12:25 P.M.
	4a. Facility Name (If not institution, give street and number) 5550 Baltimore National Pike Apt. #6		4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 220-64-3132	8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) September 20, 1963		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 11 Mt. Green Circle			10f. Zip Code 21244		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Building / Construction	
17. Father's Name (First, Middle, Last) Gilbert A. Topolski		18. Mother's Name (First, Middle, Maiden Surname) June Henderson			
19a. Informant's Name/Relationship (Type, Print) Mr. Gilbert A. Topolski Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Mt. Green Circle Catonsville, MD 21244			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery		20c. Location - City or Town, State Ellicott City, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last FOUND: HOME					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8-9-00		28b. Time of Injury UNKNOWN	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN			
28e. Location (Street and Number or Rural Route Number, City or Town, State) 5550 BALTIMORE NATIONAL PIKE CATONSVILLE BALTIMORE COUNTY, MD		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5550 BALTIMORE NATIONAL PIKE CATONSVILLE BALTIMORE COUNTY, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 10, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26265

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Billy Ray Turnage, Sr.				2. Date of Death Month 8 Day 15 Year 2000		3. Time of Death 12:45p.m.	
	4a. Facility Name (If not institution, give street and number) 220 N. Chester St.				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 241-62-5392	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5-3-40		9. Birthplace (State or Foreign Country) N.C.
	Usual Residence of Decedent							
10a. State Md.		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 220 N. Chester St.				10f. Zip Code 21231		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) 8th Grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance			16b. Kind of Business/Industry School	
17. Father's Name (First, Middle, Last) Henry Turnage				18. Mother's Name (First, Middle, Maiden Surname) Lucy Taylor				
19a. Informant's Name/Relationship (Type, Print) Ruby Turnage				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 N. Chester St., Baltimore, Md. 21231				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Pk.		20c. Location - City or Town, State 8/21/00 Dundalk, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 11 MONTHS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  Staff Physician				29c. License number 1219714		29d. Date signed (Month, Day, Year) 8/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL PURTELL, J4BVMC 4940 EASTERN AVE, BALTIMORE, MD 21224								
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26266

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THERESA A. VON GLASSNER				2. Date of Death Month Day Year AUGUST 16, 2000		3. Time of Death 5:10 A.M.	
	4a. Facility Name (If not institution, give street and number) MANOR CARE RUXTON				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-05-1772	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11/7/11		9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2918 KNOLL ACRES DRIVE				10f. Zip Code 21234		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER		16b. Kind of Business/Industry RETAIL		
17. Father's Name (First, Middle, Last) GABRIEL VALLE				18. Mother's Name (First, Middle, Maiden Surname) JOHANNA GLORIOSO				
19a. Informant's Name/Relationship (Type, Print) JACKIE WARD DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2918 KNOLL ACRES DRIVE BALTIMORE, MD 21234				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		20c. Location - City or Town, State 8/19/00 BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <div style="display: flex;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="flex: 2;"> <p>a. Gangrenous leg Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease Due to (or as a consequence of):</p> <p>c. Malnutrition Due to (or as a consequence of):</p> <p>d.</p> </div> </div>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier 				29c. License number 542736
29d. Date signed (Month, Day, Year) 8-16-00				30. Name and address of person who completed cause of death (Item 28b) (Type, Print) AYMAN AKKAD, MD 7600 OSLER DRIVE SUITE 411 TOWSON, MD 21204				
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26267

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SEVERINO M. VIANA

2. Date of Death

Month Day Year
Aug 15 2000

3. Time of Death

12:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

454 Machias Place

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

032-22-2448

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov 19, 1924

9. Birthplace (State or Foreign Country)

BRAZIL

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

454 MACHIAS PLACE

10f. Zip Code

21220

10g. Citizen of What Country?

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Caucasian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Merchant Marine

16b. Kind of Business/Industry

Seaman

17. Father's Name (First, Middle, Last)

Severino M. Viana

18. Mother's Name (First, Middle, Maiden Surname)

Carolina Unknown

19a. Informant's Name/Relationship (Type, Print)

HELENA MORRELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 CLEARWATER COURT, Baltimore, MD 21220

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

08/18/2000

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Charles Kaczorowski

22. Name and Address of Facility

Kaczorowski Funeral Home, P.A.

1201 Dundalk Avenue, Baltimore, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician:☒ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Deputy

29c. License number

D18667

29d. Date signed (Month, Day, Year)

August 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip M. Miletello, MD Shock Trauma 22 S. Greene St. Baltimore, Md 21201

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26268

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren Alexander Whealton, Jr.				2. Date of Death Month Day Year August 16, 2000				3. Time of Death 10:00 a.m.	
	4a. Facility Name (If not Institution, give street and number) 514 Cranford Road				4b. City, Town, or Location of Death Essex				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-24-5793		6. Sex XX M 20 F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) July 5, 1927		9. Birthplace (State or Foreign Country) North Carolina	
	10a. State Maryland				10b. County Baltimore		10c. City, Town or Location Essex			
To Be Completed by Funeral Director	10e. Street and Number 514 Cranford Road				10f. Zip Code 21221		10g. Citizen of What Country? U..S.A			
	11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 11		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lithographer		16b. Kind of Business/Industry Printing					
	17. Father's Name (First, Middle, Last) Warren Alexander Whealton, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mildred Hodges					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marie Joan Whealton (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Cranford Road, Baltimore, Maryland 21221					
	20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MeadowRidge Mem. Park		20c. Location - City or Town, State 8/19/2000 Baltimore, Maryland					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic colon cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 21 months					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. emphysema stroke				23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown					
					24a. Was an autopsy performed? 10 Yes 20 No		24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No			
	25. Was case referred to medical examiner? 10 Yes 20 No		26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)							
	27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 10 Yes 20 No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D45530		29d. Date signed (Month, Day, Year) Aug, 17, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SWASATHAN, 6830, suite 206, hospital drive, 21237				31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			
	State Registrar									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26269

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAUL W. WATKINS				2. Date of Death Month Day Year AUGUST 6, 2000		3. Time of Death 4:08 PM		
	4a. Facility Name (If not institution, give street and number) Lorien Frankford Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-03-2285		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) August 29, 1919 MD		
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 5009 Frankford Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Horse stable			
17. Father's Name (First, Middle, Last) John D. Watkins				18. Mother's Name (First, Middle, Maiden Surname) Mary Louise					
19a. Informant's Name/Relationship (Type, Print) Lorien Frankford Nursing 5009 Frankford Avenue, Baltimore, MD 21206				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. sepsis								Approximate Interval Between Onset and Death 5 Days	
Immediate Cause (Final disease or condition resulting in death) sepsis									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia, diabetes								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Matthew McNabney				29c. License number D45752	
				29d. Date signed (Month, Day, Year) August 14, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW MCNABNEY 5565 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224									
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature Barbara G. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26270

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elenora B. Warner

2. Date of Death

08

Day

16

Year

2000

3. Time of Death

3:40AM

4a. Facility Name (If not institution, give street and number)

Edenwald Nursing Home

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-28-6984

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 16, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

216 Chantry Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward Richmond Holden

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Blanche Ports

19a. Informant's Name/Relationship (Type, Print)

Mildred Wannen/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 Chantry Road Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

Aug. 18, 2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Michael J. Flagle

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

b.

Due to (or as a consequence of):

Acute Respiratory Insufficiency

c.

Due to (or as a consequence of):

Arteriosclerotic Disease

d.

Approximate Interval Between Onset and Death

< 1 wk

< 1 wk

10 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Signature and title of certifier

29e. License number

D 29769

29f. Date signed (Month, Day, Year)

8/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wesley D. Moore

516 N. Rolling Rd Baltimore 21228

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26271

Physician
/Medical
Examiner1. Decedent's Name (First, Middle, Last)
HELEN E. WILLIAMS2. Date of Death
Month Day Year
AUG. 15 20003. Time of Death
17:05 PMFuneral
Director4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL - ER4b. City, Town, or Location of Death
Baltimore City4c. County of Death
Baltimore City5. Social Security Number
214-01-69576. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
80 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
Dec. 17, 19199. Birthplace (State or Foreign
Country)
Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Baltimore City

Baltimore City

XX Yes 2 ☐ No10e. Street and Number
4224 Parkmont Avenue10f. Zip Code
2120610g. Citizen of What Country?
USA11. Marital Status
1 ☐ Never Married 2 ☐ Married
XX ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12)
10th gradeCollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Housewife16b. Kind of Business/Industry
Homemaking-Own Home17. Father's Name (First, Middle, Last)
Christian Redeman18. Mother's Name (First, Middle, Maiden Surname)
Anna Elizabeth Malkus19a. Informant's Name/Relationship (Type, Print)
Kenneth J. Krach19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1814 Wilson Point Rd. Baltimore, Md. 2122020a. Method of Disposition
XX ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)
Gardens of Faith Cem. 8-18-00

Date

20c. Location - City or Town, State
Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE > 10 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, TYPE 2HYPERTENSION, ESSENTIALRENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8552 PAULADELPHIA RD., BALTIMORE, MD 21237

State
Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 18 2000

Bennett Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26272

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emogene Fredricka Williams				2. Date of Death Month 8 Day 10 Year 00		3. Time of Death 1401		
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a		
Funeral Director	5. Social Security Number 219-22-7132		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Dec 12, 1927		
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Woodlawn		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Baltimore Civic League	
17. Father's Name (First, Middle, Last) Fred Archey				18. Mother's Name (First, Middle, Maiden Surname) Elnora Lorick					
19a. Informant's Name/Relationship (Type, Print) sister Addie Keys				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7408 Fairbrook Road 2A Baltimore, MD 21244					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park				20c. Location - City or Town, State Baltimore County, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. RENAL FAILURE Due to (or as a consequence of): b. HEPATIC FAILURE Due to (or as a consequence of): c. PROBABLE SEPSIS Due to (or as a consequence of): d. POSTOP SMALL BOWEL OBSTRUCTION, RENAL ABSCESS				Approximate Interval Between Onset and Death 10 DAYS 3-4 DAYS 14 DAYS 14 DAYS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROSIS, GENERALIZED RENAL ARTERY STENOSIS WITH ATROPHY LEFT KIDNEY NEPHROSCLEROSIS				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier William J. Hicken, Jr. D.				29c. License number D-04964	
29d. Date signed (Month, Day, Year) AUGUST 11, 2000				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM J. HICKEN, MD ST AGNES HEALTHCARE 900 CATON AVE BALTIMORE, MD 21229					
31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature 					

ORIGINAL

00-4546-013

AUGUSTUS WOODARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26273

ASP

amend item 23a,pt.II 27 per me G788 10/3/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Augustus Cleveland Woodard, III		2. Date of Death Month Day Year AUGUST 14 2000		3. Time of Death 0705
	4a. Facility Name (If not institution, give street and number) CARROLL COUNTY CENTRAL LAUNDRY CAMP		4b. City, Town, or Location of Death SYKESVILLE		4c. County of Death CARROLL
Funeral Director	5. Social Security Number 212-50-1265	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	8. Date of Birth (Month, Day, Year) 03/31/1952	
	10a. State MD		10b. County N/A	10c. City, Town or Location Baltimore	
10e. Street and Number 1718 E. Fayette St.		10f. Zip Code 21231		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction	
17. Father's Name (First, Middle, Last) Augustus Cleveland Woodard, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Lola Guess			
19a. Informant's Name/Relationship (Type, Print) Martina Woodard/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 Comet Pl., Baltimore, MD 21201			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Cemetery		20c. Location - City or Town, State 08/22/00 Germantown, MD	
21. Signature of Funeral Service Licensee Wesley Charis		22. Name and Address of Facility Chavis Funeral Home, P.A., 2007-09 Eastern Av. Baltimore, MD 21231 - (410) 342-7400			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL FIBROSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FOCAL ACUTE PANCREATITIS		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes <input type="checkbox"/> No	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Wayne McNeill MD		29c. License number O.C.M.E	
		29d. Date signed (Month, Day, Year) AUGUST 14, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND D. KORSH		111 Penn Street, Baltimore, Maryland 21201			
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26274

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELVIRA ADDISON				2. Date of Death Month Day Year AUGUST 04 2000		3. Time of Death 0114	
	4a. Facility Name (If not institution, give street and number) KENT & QUEEN ANNES HOSPITAL				4b. City, Town, or Location of Death CHESTERTOWN		4c. County of Death KENT	
Funeral Director	5. Social Security Number 061-24-2503	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03 19 32		9. Birthplace (State or Foreign Country) NEW YORK CITY
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State NY	10b. County NEW YORK CITY	10c. City, Town or Location PEEKSKILL			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 136 LOWER SOUTH ST.			10f. Zip Code 10566		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY		16b. Kind of Business/Industry VETERANS ADMINISTRATION			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) HAZEL FORD			
	19a. Informant's Name/Relationship (Type, Print) WILBUR E. JOHNSON - COUSIN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 257 Chestertown, MD 21620			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAPITOL CREMATORY		20c. Location - City or Town, State 8-5-00 Dover Delaware			
	21. Signature of Funeral Service Licensee Joyce O. Walley		22. Name and Address of Facility Walley Funeral Service Chestertown, MD 21620					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular accident							Approximate Interval Between Onset and Death
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Andrew Ferguson MD				29c. License number D005178		29d. Date signed (Month, Day, Year) 8/04/00		
29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Andrew Ferguson 120 Speer Rd. Suite 2 Chestertown MD 21620								
31. Date filed (Month, Day, Year) AUG 7 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Aug 5 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26275

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROZELLA BOOKER.		2. Date of Death Month July Day 27 Year 2000		3. Time of Death 1745
	4e. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 216-18-2433	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JULY 20, 1924		9. Birthplace (State or Foreign Country) SALISBURY, MD.		
Usual Residence of Decedent					
10a. State MD.		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 531 W. ISABELLA ST.			10f. Zip Code 21801		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry HOUSEWIFE	
17. Father's Name (First, Middle, Last) GORDY HOPKINS			18. Mother's Name (First, Middle, Maiden Surname) MAMIE WHITE		
19a. Informant's Name/Relationship (Type, Print) PATSY HORSEY			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 W. ISABELLA STREET, SALISBURY, MD. 21801		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) John WESLEY UM CHR. CEM.		20c. Location - City or Town, State 8-3-00 WESTOVER, MD.	
21. Signature of Funeral Service Licensee Loretta B. Jolley		22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. SEPSIS					
Due to (or as a consequence of):					
b. PNEUMONIA					
Due to (or as a consequence of):					
c. TYPE TWO DIABETES					
Due to (or as a consequence of):					
d.					
Approximate Interval Between Onset and Death 18 DAYS 18 DAYS 10 YEARS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 3 MP		29c. License number 100046029		29d. Date signed (Month, Day, Year) JULY 27 2000.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL K. GARUBA, MD 12137 ELM STREET, PRINCESS ANNE, MD 21873					
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature B. Sparks			

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State of Maryland / Department of Health and Mental Hygiene

00 26276

Amend #'s 4b. & 4c. Per Phys. PGC 7-27-2000 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLIE EARL BURNEY				2. Date of Death Month Day Year JULY 22 2000		3. Time of Death 3:33 PM	
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death Lanham Prince George Co.		4c. County of Death Prince George's Lanham, Maryland	
Funeral Director	5. Social Security Number 240-44-1118	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 24, 1930		9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George		10c. City, Town or Location Lanham, Maryland			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 7211 Kempton Road Lanham Maryland				10f. Zip Code 20706		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Correctional Officer			16b. Kind of Business/Industry Dept. of Corrections Colo. Springs, Colo.	
17. Father's Name (First, Middle, Last) George Burney				18. Mother's Name (First, Middle, Maiden Surname) Harriett Green				
19a. Informant's Name/Relationship (Type, Print) Eloise Burney				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7211 Kempton Road Lanham, Maryland 20706				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery		20c. Location - City or Town, State Washington, D.C.		
21. Signature of Funeral Service Licensee E.M. DUDLEY				22. Name and Address of Facility E. M. DUDLEY FUNERAL HOME 20712 3200 RHODE ISLAND AVENUE MOUNT RAINIER, MD.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Brain hemorrhage Due to (or as a consequence of): b. Brain herniation Due to (or as a consequence of): c. Increased intracranial pressure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Stroke						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier Aleem A. Iqbal				
				29c. License number D26428		29d. Date signed (Month, Day, Year) 7/26/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ALEEM A. IQBAL 7525 GREENWAY CENTER DR. GREENBELT MD 20770								
31. Date filed (Month, Day, Year) JUL 27 2000				32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Items 10f, 19b per F.D State of Maryland / Department of Health and Mental Hygiene
08/08/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 26277

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRY CALVIN CLAGETT				2. Date of Death Month 08 Day 05 Year 2000		3. Time of Death 0545
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll
Funeral Director	5. Social Security Number 218-28-4326	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sep 29, 1910	
	9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent				
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 250 Saint Lukes Circle				10f. Zip Code 21157 21158		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Serviceman		16b. Kind of Business/Industry Suburban Propane	
17. Father's Name (First, Middle, Last) John Adam Clagett				18. Mother's Name (First, Middle, Maiden Surname) Nellie Long			
19a. Informant's Name/Relationship (Type, Print) Mary Clagett, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 Saint Lukes Cr, Westminster, Md 21157 21158			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hampstead Cemetery		20c. Date 8/8		20d. Location - City or Town, State Hampstead, MD	
21. Signature of Funeral Service Licensee Steven W. Elene MQ0723				22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. longest time Heart Failure Dued (or as a consequence of): b. Aortic Valve disease Dued (or as a consequence of): c. Atrial fibrillation Dued (or as a consequence of): d. 							Approximate Interval Between Onset and Death years years years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Frederick H. D				29c. License number D38915		29d. Date signed (Month, Day, Year) 8/5/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREID 295 Stoner Ave Westminster MD 21157							
31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature Benjamin B. Sparks					

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1900
1901
1902

1903
1904
1905



1906
1907
1908

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26278

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH WAYNE CAREY			2. Date of Death Month July Day 30 Year 2000		3. Time of Death 4:58 PM	
	4a. Facility Name (If not institution, give street and number) 119 Liberty Way			4b. City, Town, or Location of Death Fruitland		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 217-30-9992		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 16, 1935
	9. Birthplace (State or Foreign Country) Salisbury						
Usual Residence of Decedent							
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Fruitland		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 119 Liberty Way				10f. Zip Code 21826		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Air Force		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Electrician		16b. Kind of Business/Industry Electric	
17. Father's Name (First, Middle, Last) William Mark Carey				18. Mother's Name (First, Middle, Maiden Surname) Minerva Wilson			
19a. Informant's Name/Relationship (Type, Print) Robin Carey/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6005 Farming Ridge Blvd, Reading, PA 19606			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		Date 8/3/00		20c. Location - City or Town, State Hebron, MD	
21. Signature of Funeral Service Licensee David H. Thompson MD051				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. Ventricular Arrhythmia					Approximate Interval Between Onset and Death 5 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Dilated Cardiomyopathy					Years
		c. _____					
		d. _____					
		Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulm. Dz.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Joseph C. Cindrum, MD				29c. License number 044069		29d. Date signed (Month, Day, Year) 8-1-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH CINDRUM, MD 106 MILFORD #605 SALISBURY MD 21804							
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 26279**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George F. Duckett				2. Date of Death Month August Day 4 , Year 2000		3. Time of Death 1:00 pm	
	4a. Facility Name (If not institution, give street and number) 8923 Heather Moore Blvd. Apt. 104				4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 217-36-9773		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 11, 1932	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince Georges	
To Be Completed by Funeral Director	10c. City, Town or Location Upper Marlboro				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 8923 Heather Moore Blvd Apt. 104				10f. Zip Code 20772		10g. Citizen of What Country? U.S.A	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 54-56		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Prince Georges Board Of Education			
17. Father's Name (First, Middle, Last) Richard E. Duckett				18. Mother's Name (First, Middle, Maiden Surname) Mary E. Watson				
19a. Informant's Name/Relationship (Type, Print) Lillian Duckett/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 Maryland Upper Marlboro				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cem. August 10, 2000 Cheltenham MD				
21. Signature of Funeral Service Licensee				22. Name and Address of Facility M191 Adams Funeral Home P.A. Aquasco Maryland 20608				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): Leukopenia Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier A. Rahimian MD		29c. License number D0052999		29d. Date signed (Month, Day, Year) 08/07/00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ALI RAHIMIAN MD								
State Registrar	31. Date filed (Month, Day, Year) 08/07/00		32. Registrar's Signature AUG 08 2000					

Baltimore, Maryland 21215-0020

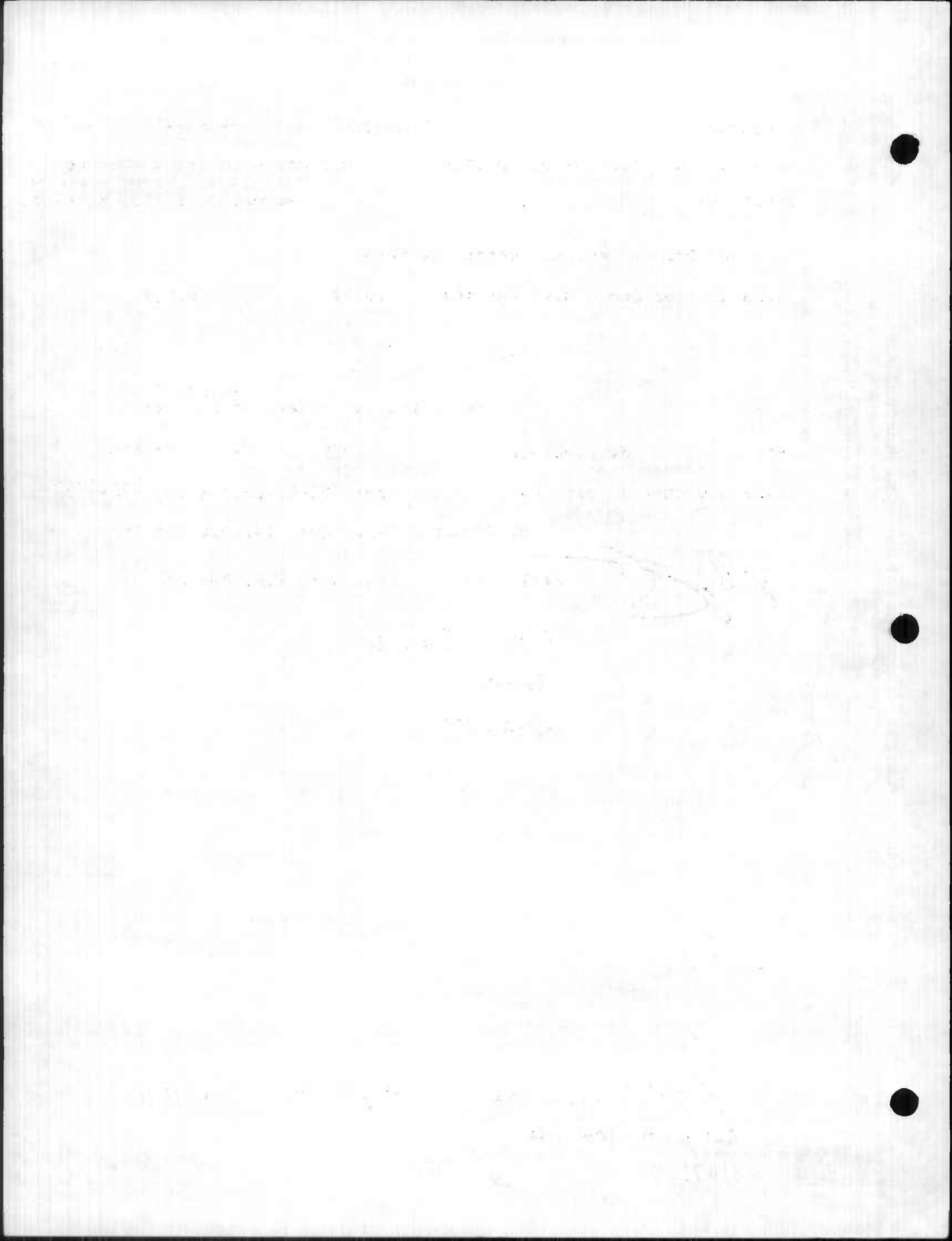
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



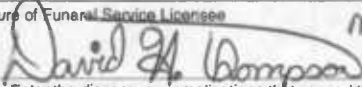

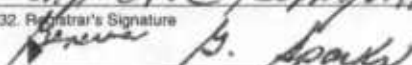
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26280

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAURICE RAYMOND DAVIS				2. Date of Death Month 07 Day 31 Year 00		3. Time of Death 9:47 Am		
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER		
Funeral Director	5. Social Security Number 214-32-2008		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 5, 1930	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Pittsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 34998 Poplar Neck Rd				10f. Zip Code 21850		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager			16b. Kind of Business/Industry Courier Service		
17. Father's Name (First, Middle, Last) George W. Davis				18. Mother's Name (First, Middle, Maiden Surname) Mildred Shockley					
19a. Informant's Name/Relationship (Type, Print) Joan W. Davis/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34998 Poplar Neck Rd., Pittsville, MD 21850					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pittsville Cemetery		20c. Location - City or Town, State Pittsville, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Pulmonary Embolism Due to (or as a consequence of): Rib Fractures								Approximate Interval Between Onset and Death	
Part II: Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Sclerium Hepatic insufficiency Metastatic Mucinous Cancer								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number 0-0048221		29d. Date signed (Month, Day, Year) 7/31/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR JULIO DERENA 18 WILSON AVE SHIP CTR, SELBYVILLE DE 19975									
31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

7/31/00 0947

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

7. The seventh part of the report deals with the results of the work during the year and the progress of the work during the year.

8. The eighth part of the report deals with the results of the work during the year and the progress of the work during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 27 per phys. G786 8/18/00 yg

Certificate of Death

Reg. No.

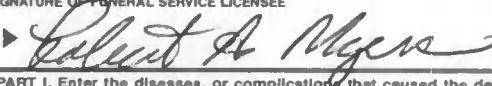


00 26281

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGNES GUNNING DUKES				2. Date of Death Month July Day 26 Year 2000		3. Time of Death 0215	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 220-26-1457		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 23, 1915	
	9. Birthplace (State or Foreign Country) Scotland		10a. State MD		10b. County Caroline		10c. City, Town or Location Federalsburg	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 412-15 Liberty Road		10f. Zip Code 21632	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laundress				16b. Kind of Business/Industry Laundry/Dry Clean.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Francis Douglas				18. Mother's Name (First, Middle, Maiden Surname) Martha O'Connell			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Marty Smith/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412-15 Liberty Rd., Federalsburg, MD 21632			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hill Crest Cemetery		20c. Location - City or Town, State Federalsburg, MD	
	21. Signature of Funeral Service Licensee Michael F. Eskow				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoglycemia Due to (or as a consequence of): b. Metastatic Pancreatic Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 4 days 2 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① DM ② Coronary Artery Disease ③ COPD ④ Renal Insuff. cency						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier El. Zabe Nega MD				29c. License number D46366		29d. Date signed (Month, Day, Year) 07-26-00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH NEGA, MD 219 S. WASHINGTON ST, EASTON, MD 21601							
	31. Date filed (Month, Day, Year) JUL 27 2000				32. Registrar's Signature [Signature]			

00 26282

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RALPH EAGLE				2. DATE OF DEATH MONTH 08 DAY 05 YEAR 2000		3. TIME OF DEATH 0445 M	
4. SOCIAL SECURITY NUMBER 212-46-2178		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 19, 1947	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Eastern Correctional Center		9b. CITY, TOWN OR LOCATION OF DEATH Princess Anne	
9c. COUNTY OF DEATH Somerset				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Finksburg				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2201 Old Westminster Pike	
10f. ZIP CODE 21048				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Forklift Operator		16b. KIND OF BUSINESS/INDUSTRY Factory	
17. FATHER'S NAME (First, Middle, Last) William Henry Eagle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maxine Mayle			
19a. INFORMANT'S NAME (Type/Print) Ralph E. Eagle, Jr/son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Whip Lane, Glen Burnie, MD 21060			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Memorial Gardens 8/8		20c. LOCATION — City or Town, State Finksburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 91 Willis Street Westminster, MD 21157			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE 710 YRS DUE TO (OR AS A CONSEQUENCE OF): b. COPULMONALS DUE TO (OR AS A CONSEQUENCE OF): c. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PRISON			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D0050826		29d. DATE SIGNED (Month, Day, Year) 08/05/2000	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAZAAK A. ENIOLA ECI 30420 REVELL'S WICK RD, WESTOVER MD 21890							
31. DATE FILED (Month, Day, Year) AUG 07 2000				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

RALPH EDWARD EAGLE, SR.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26283

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Walter Perrine Green</i>				2. Date of Death Month <i>Aug</i> Day <i>5</i> Year <i>2000</i>		3. Time of Death <i>10:42 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>				4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard County</i>	
Funeral Director	5. Social Security Number <i>213-20-4531</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>75</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov 28, 1924</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>MD</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Ellicott City</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <i>3367 F North Chatham Road</i>		10f. Zip Code <i>21042</i>	
	10g. Citizen of What Country? <i>U.S.A.</i>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1943-46</i>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Accountant</i>				16b. Kind of Business/Industry <i>Professional</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>George Green</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Rosa Dell</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Gene A. Green (Wife)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3367F North Chatham Road Ellicott City, MD 21042</i>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>All County Cremation Serv.</i>		20c. Location - City or Town, State <i>8/6/2000 Sykesville MD</i>	
	21. Signature of Funeral Service Licensee <i>Brian D. Haight</i>				22. Name and Address of Facility <i>HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410-795-1400)</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Myocardial infarction</i>						Approximate Interval Between Onset and Death <i>1 day</i>	
	Due to (or as a consequence of): b. <i>Due to (or as a consequence of):</i> c. <i>Due to (or as a consequence of):</i> d. <i>Due to (or as a consequence of):</i>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pancreatic cancer</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <i>Brian D. Haight Intendist</i>	
To Be Completed by Physician/Medical Examiner	29c. License number <i>D37013</i>		29d. Date signed (Month, Day, Year) <i>Aug. 5, 2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bruce M Conger MD #205, 11055 Little Patuxent Pkwy Columbia, MD 21044</i>			
	31. Date filed (Month, Day, Year) <i>AUG 08 2000</i>		32. Registrar's Signature <i>B. Sparks</i>					

Amended Item 19a & Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 10c per F.D. State of Maryland / Department of Health and Mental Hygiene

08/07/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 26284

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lydia Gonsalves

2. Date of Death

Month
AugustDay
5Year
2000

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

Westminster Nursing and
Convalescent Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

020-01-7106

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 27, 1908

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

~~Westminster Nursing and
Convalescent Center~~

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1234 Washington Rd.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Portuguese

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Manuel Machado

18. Mother's Name (First, Middle, Maiden Surname)

Mary Souza

19a. Informant's Name/Relationship (Type, Print)

Richard Gonsalves - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2723 Fridinger Mill Rd.
Manchester, MD 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. John Cemetery

Date

Aug. 9, 2000

20c. Location - City or Town, State

New Bedford, MA

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility

Pritts Funeral Home and Chapel, P.A.

412 Washington Rd. Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Breast Cancer

Approximate Interval Between Onset and Death

6 yrs

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert L. Moss, MD

29c. License number

032802

29d. Date signed (Month, Day, Year)

8/6/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Moss 114 Business Center Dr. Reisterstown, MD 21136

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26285

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARA ODDO GIARRUSSO				2. Date of Death Month Day Year AUG. 2 2000		3. Time of Death 3:00 PM	
	4a. Facility Name (If not institution, give street and number) CHESTERTOWN NURSING & REHABILITATION CTR				4b. City, Town, or Location of Death CHESTERTOWN		4c. County of Death KENT	
Funeral Director	5. Social Security Number 335-01-1011		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) MAY 26, 1902	
	9. Birthplace (State or Foreign Country) ITALY		10a. State MD		10b. County KENT		10c. City, Town or Location CHESTERTOWN	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 200 WALTER DRIVE		10f. Zip Code 21620	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -0-	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLY WORKER				16b. Kind of Business/Industry ELECTRIC SUPPLY CO.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) ROSS ODDO				18. Mother's Name (First, Middle, Maiden Surname) ANTOINETTE DOMINO			
	19a. Informant's Name/Relationship (Type, Print) SALVINA BENJAMIN/ DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 WALTER DRIVE, CHESTERTOWN, MD 21620			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) RIDGWOOD CEMETERY		20c. Location - City or Town, State 8-7-00 DES PLAINES, IL	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR ARRHYTHMIA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 2 min. 2 weeks			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE ADVANCED AGE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
To Be Completed by Physician/Medical Examiner	29c. License number D 0041587				29d. Date signed (Month, Day, Year) 8/3/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELEN A. NOBLE, M.D., 122 SPEER ROAD, CHESTERTOWN, MD 21620				31. Date filed (Month, Day, Year) AUG 4 2000			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 				33. Date of Death AUG 4 2000			
	34. State Registrar AUG 4 2000				35. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26286

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Mae Glenn				2. Date of Death Month Day Year August 8, 2000		3. Time of Death 7:00 p.m.	
	4a. Facility Name (If not Institution, give street and number) 5865 Williams Street				4b. City, Town, or Location of Death Rock Hall		4c. County of Death Kent	
Funeral Director	5. Social Security Number 220-26-3273		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) January 14, 1926	
	9. Birthplace (State or Foreign Country) Rock Hall, MD		10. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall	
To Be Completed by Funeral Director	10e. Street and Number 5865 Williams Street		10f. Zip Code 21661		10g. Citizen of What Country? USA		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Melvin L. Glenn	
	18. Mother's Name (First, Middle, Maiden Surname) Mary S. Kelley		19a. Informant's Name/Relationship (Type, Print) Patsy Higgs		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5865 Williams Street, Rock Hall, Maryland 21661		20. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 20 years	
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left Cerebrovascular Accident Arteriosclerotic Cardiovascular Disease Congestive Heart Failure	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number D17036		29d. Date signed (Month, Day, Year) 8/9/00		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Susan K. Ross M.D. 516 Washington Ave. Chestertown Md. 21620	
	31. Date filed (Month, Day, Year) AUG 9 2000		32. Registrar's Signature 		State Registrar		Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26287

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARCIA

LOUISE

GIBBON

2. Date of Death

Month
AUGUST

Day

2,

Year

2000

3. Time of Death

7:35 P.M.

4a. Facility Name (If not Institution, give street and number)

BERLIN NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

202-07-7418

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
August 10, 1918

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Pennsylvania

10b. County

Chester

10c. City, Town or Location

West Chester

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

926 Lea Drive

10f. Zip Code

19382

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Packaging Machine Co.

17. Father's Name (First, Middle, Last)

Walter G. Gibbon

18. Mother's Name (First, Middle, Maiden Surname)

Marion

Gilpin

19a. Informant's Name/Relationship (Type, Print)

C. Gilpin Gibbon/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

926 Lea Dr., West Chester, PA 19382

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Salisbury Crematory

Date

8/3/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home Professional Association

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Corticosteroids

Silent Bradycardia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)X ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

Aug 3-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811 410-641-4400

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

GIBBON, MARCIA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26288

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL HELEN HESSON

2. Date of Death

Month Day Year
AUGUST 9 2000

3. Time of Death

5:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6006 New Forest Court Apt. 4

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

5. Social Security Number

482-24-4728

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 13, 1928

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6006 New Forest Court Apt. 4

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Aloysius Schroeder

18. Mother's Name (First, Middle, Maiden Surname)

Johnna Schroder

19a. Informant's Name/Relationship (Type, Print)

Albert R. Hesson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6006 New Forest Ct. Apt. 4 Waldorf, MD 20602

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 8-12-00 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MO0173

22. Name and Address of Facility

Eberwein Funeral Services

4433 White Pls. La. White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Ischemic heart disease.

Due to (or as a consequence of):

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yahia H. Tagour, MD

29c. License number

D0650883

29d. Date signed (Month, Day, Year)

8-10-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11655 Winesap Pl La Plata MD 20646

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

March 10, 1932

Dear Mr. [illegible]

Very much interested in your letter of March 8.

I am sorry that I cannot give you a more definite answer at present.

Yours truly,

[illegible]

Very truly,

[illegible]

Enclosed for you are

two copies of the report

of the committee on the subject of the proposed new building.

I am sure that you will find it of interest.

Sincerely,

[illegible]

Very truly,

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26289

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT L. HOPKINS				2. Date of Death Month: JUL. Day: 28 Year: 2000		3. Time of Death 1026AM
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER
Funeral Director	5. Social Security Number 241-64-2842	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth Month: APR. Day: 29 Year: 1940	9. Birthplace (State or Foreign Country) Littleton, N.C.
	Usual Residence of Decedent						
10e. State MD.		10b. County WORCESTER		10c. City, Town or Location BERLIN		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 10027 HUCKLEBERRY LANE				10f. Zip Code 21811		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry TRUCK DRIVER/Crane OP.	
17. Father's Name (First, Middle, Last) TOMMIE HOPKINS				18. Mother's Name (First, Middle, Maiden Surname) BETSY CARTER			
19a. Informant's Name/Relationship (Type, Print) GAIL HOPKINS/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5016 WOODLANDS GLEN RD., BALTIMORE, MD. 21209			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. PAUL UM CHR. CEM.		Date 8-4-2000		20c. Location - City or Town, State BERLIN, MD.	
21. Signature of Funeral Service Licensee Loretta B. Jolley				22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD, SALISBURY, MD. 21801			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arrest Due to (or as a consequence of): Cardiomyopathy Due to (or as a consequence of): Coronary artery disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sub-acute Bacterial Dysentery Dysentery							Approximate Interval Between Onset and Death Months Years Years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sub-acute Bacterial Dysentery Dysentery						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Dr. Constante M.D.				29c. License number MD 16725		29d. Date signed (Month, Day, Year) 7/28/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TAN, CONSTANCE 547-G Riverside Dr. Solby, MD 21801							
31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature B. Sparks					

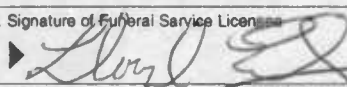
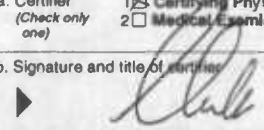
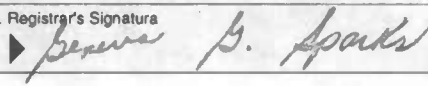
ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26290

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William M. Jenkins		2. Date of Death Month August Day 4 Year 2000		3. Time of Death 16:50
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 577-14-6656	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	8. Date of Birth (Month, Day, Year) July 3, 1910	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Charles	10c. City, Town or Location Waldorf		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 3515 Metro Gun Place		10f. Zip Code 20601		10g. Citizen of What Country? U.S.A
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Kind of Business/Industry Construction
	15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Skilled Labor		16b. Kind of Business/Industry Construction		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Alice Jenkins		
	19a. Informant's Name/Relationship (Type, Print) Virgie L. Jenkins /Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3515 Metro Gun Place, Waldorf Maryland 20601		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cem. August 11, 2000 Waldorf MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility M191 Adams Funeral Home P.A. Aquasco MD 20608		
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION Due to (or as a consequence of): MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. THIRD DEGREE HEART BLOCK				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7501		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number D53885	
		29d. Date signed (Month, Day, Year) 8/7/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENKAT. S. RAMANAN 7501 SUNDATTS ROAD #307 CLINTON MD 20735					
State Registrar	31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26291

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Antoniette Johnson				2. Date of Death Month Day Year August 9 2000		3. Time of Death 1950	
	4a. Facility Name (If not institution, give street and number) The Kent & Queen Anne's Hospital, Inc.				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 213-22-7528		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 6, 1912	
	10a. State MD		10b. County Kent		10c. City, Town or Location Chestertown		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 415 Morgnec Road				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Private Families			
	17. Father's Name (First, Middle, Last) James A. Johnson				18. Mother's Name (First, Middle, Maiden Surname) Margaret Graves			
	19a. Informant's Name/Relationship (Type, Print) Marian Johnson - Sister-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 280 West Madison St., Easton, PA 18042			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Emmanuel Cemetery		20c. Location - City or Town, State 8-14-00 Chestertown			
	21. Signature of Funeral Service Licensee James A. Perkins				22. Name and Address of Facility James A. Perkins Funeral Service P. O. Box 143 - 21106 Rock Hall Ave. Rock Hall, MD 21661			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① CHF ② Chronic Renal Failure ③ Gastrointestinal Bleeds ④ Old CVA							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier James A. Perkins, M.D.				29c. License number D 21313		29d. Date signed (Month, Day, Year) 8/11/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KIN K. WUN 415 Washington Ave, Chestertown, MD 21620								
31. Date filed (Month, Day, Year) AUG 11 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

LEON
KOSTKOWSKIState of Maryland / Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27, 28A-F8-24-00 WB
Certificate of Death

Reg. No. 00 26292

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leon Joseph Kostkowski Sr.				2. Date of Death Month AUGUST Day 12 Year 2000		3. Time of Death 6:30P.M.	
	4a. Facility Name (If not institution, give street and number) 105 1st STREET				4b. City, Town, or Location of Death RIDGELY		4c. County of Death CAROLINE	
Funeral Director	5. Social Security Number 212-42-3841		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) Jan 5, 1945	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland 10b. County Caroline 10c. City, Town or Location Ridgely		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1962-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) machinist		16b. Kind of Business/Industry poultry				
17. Father's Name (First, Middle, Last) Robert Kostkowski				18. Mother's Name (First, Middle, Maiden Surname) Julianna Hoppa				
19a. Informant's Name/Relationship (Type, Print) Frances Kostkowski wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Maryland Ave Ridgely, Maryland 21660				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ridgely Cemetery		20c. Location - City or Town, State Ridgely, Maryland		20d. Date Aug 16, 2000		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fleagle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARBON MONOXIDE POISONING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 8-12-00		28b. Time of Injury 5:55 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred INHALED EXHAUST		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AUTO IN AUTO		28f. Location (Street and Number or Rural Route Number, City or Town, State) 105 1st STREET RIDGELY, MARYLAND		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 13, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute no 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

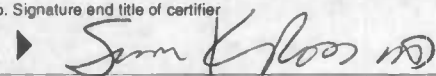
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26293

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Lavina LeCates						2. Date of Death Month Day Year August 7, 2000		3. Time of Death 11:35 a.m.	
	4a. Facility Name (If not institution, give street and number) Magnolia Hall Nursing home						4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 212-10-0270		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1905		9. Birthplace (State or Foreign Country) Chestertown, MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 24625 Chestertown Road				10f. Zip Code 21620		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator			16b. Kind of Business/Industry Telephone/Communication		
	17. Father's Name (First, Middle, Last) George V. Hatcherson						18. Mother's Name (First, Middle, Maiden Surname) Eva Downey Hatcherson Lee			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joan Hatcherson						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22912 Bayshore Road, Chestertown, Maryland 21620			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery		Date 8/9/2000		20c. Location - City or Town, State Chestertown, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helffenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> 10 years Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Anemia</u>									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 					29c. License number D17036		29d. Date signed (Month, Day, Year) 8/8/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan K. Ross MD 516 Washington Ave. Chestertown MD 21620									
	31. Date filed (Month, Day, Year) AUG 8 2000					32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26294

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Elizabeth Beasten Miller

2. Date of Death
Month Day Year

August 7, 2000

3. Time of Death

5:20 a.m.

4a. Facility Name (If not institution, give street and number)

Chestertown Nursing & Rehab. Center

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

213-24-2356

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 13, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Kennedyville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12570 Augustine Herman Highway

10f. Zip Code

21645

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Samuel Hill Beasten

18. Mother's Name (First, Middle, Maiden Surname)

Emma Grantlin

19a. Informant's Name/Relationship (Type, Print)

Rebecca Startt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5765 Langford Bay Road, Chestertown, MD 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chester Cemetery

Date

8/10/2000

20c. Location - City or Town, State

Chestertown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D1703C- Md.

29d. Date signed (Month, Day, Year)

8/7/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan K. Ross 516 Washington Ave Chestertown MD 21620

31. Date filed (Month, Day, Year)

AUG 8 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

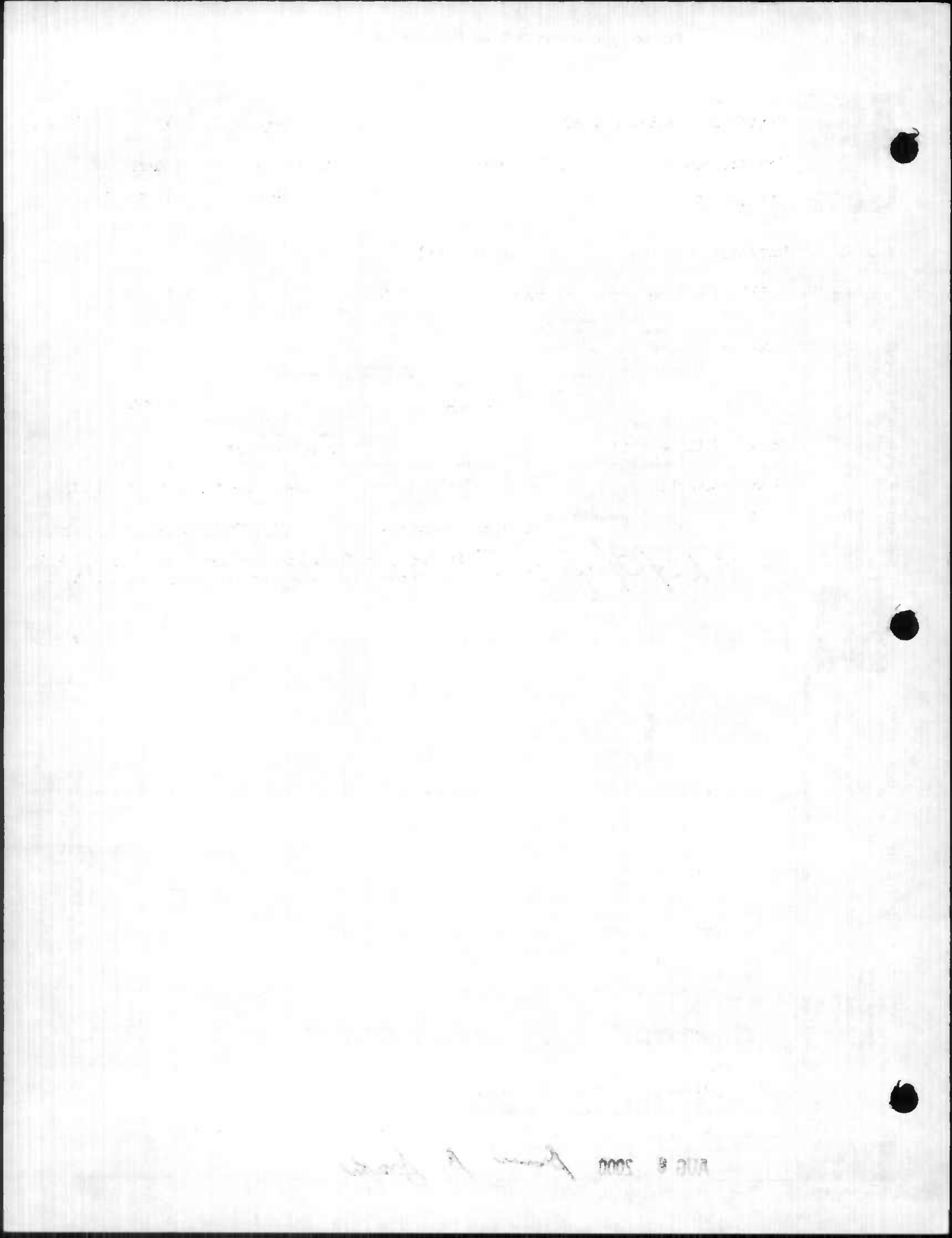
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26295

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) PAUL FREDERICK MILLER JR.				2. Date of Death Month Day Year AUG 13, 2000		3. Time of Death 3:20 PM	
4a. Facility Name (If not institution, give street and number) 3120 WHITE HALL RD				4b. City, Town, or Location of Death WHITE HALL		4c. County of Death HARFORD	
5. Social Security Number 214-36-9317		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 17, 1913	
9. Birthplace (State or Foreign Country) Maryland		10e. State MD		10b. County Harford		10c. City, Town or Location White Hall	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3120 White Hall Road		10f. Zip Code 21161		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farmer		16b. Kind of Business/Industry Dairy			
17. Father's Name (First, Middle, Last) John Henry Miller				18. Mother's Name (First, Middle, Maiden Surname) Mary Rose Lydenglous			
19a. Informant's Name/Relationship (Type, Print) Gary Miller / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3120 White Hall Rd. White Hall, MD 21161			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Presbyterian Cemetery		20c. Date Aug 16, 2000		20d. Location - City or Town, State White Hall, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St. New Freedom, PA 17349			

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A S C U D Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last HYPERTENSION DIABETES MELLITUS Type II				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) AUG 13, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRABHO M.D 728 BELAIR MD BELAIR MD 21014					
31. Date filed (Month, Day, Year) AUG 18 2000		32. Registrar's Signature 			

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26296

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LORAIN ELLINGSWORTH MESSICK

2. Date of Death

Month

Day

Year

7 30 2000

3. Time of Death

0237

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

216-14-2275

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUG. 21, 1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SEAFORD

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

709 EAST IVY DRIVE

10f. Zip Code

19973

10g. Citizen of What Country?

AMERICA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11YRS

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GARMENT CUTTER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

CLIFTON MASSEY

18. Mother's Name (First, Middle, Maiden Surname)

MABEL VIRGINIA MESSICK

19a. Informant's Name/Relationship (Type, Print)

HELEN L. MESSICK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 EAST IVY DRIVE SEAFORD, DELAWARE 19973

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ODD FELLOWS CEMETERY

Date

8/2/00

20c. Location - City or Town, State

SEAFORD, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WATSON-YATES FUNERAL HOME, INC.
SEAFORD, DELAWARE 19973

Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES FOLASHADE MD 9 108 PINEBURR RD SALISBURY MD 21801

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

~~Handwritten scribble~~

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26297

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM MCCONNELL				2. Date of Death Month AUGUST Day 1 Year 2000		3. Time of Death 11 05	
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 120-18-4402	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 31, 1928		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 606 Eton Circle				10f. Zip Code 21804		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Korea Marines If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking		
17. Father's Name (First, Middle, Last) William McConnell				18. Mother's Name (First, Middle, Maiden Surname) Florence Birch				
19a. Informant's Name/Relationship (Type, Print) Paula J. McConnell/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Eton Circle, Salisbury, MD 21804				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 8/2/00		20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee David H. Thompson MO1051				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. BILATERAL PNEUMONIA. Due to (or as a consequence of): b. ALZHEIMERS DISEASE Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier DAVID H. THOMPSON ATTENDING				29c. License number D0046029		29d. Date signed (Month, Day, Year) AUGUST 1 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL K. GARUBA, MD 17137 ELM STREET, PRINCESS ANN, MD 21853								
31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature B. Sparks				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26298

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET ORTH

2. Date of Death

Month Day Year
July 28 2000

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

DEER'S HEAD CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

197-26-1641

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
November 4, 1934

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Tyaskin

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3461 Tyaskin-Nanticoke Rd

10f. Zip Code

21865

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9College (1-4 or 5+)
-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maid

16b. Kind of Business/Industry

Motel

17. Father's Name (First, Middle, Last)

Lloyd Everett Orth

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Landolfi

19a. Informant's Name/Relationship (Type, Print)

Catherine J. Bailey/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 105, Tyaskin, MD 21865

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Salisbury Crematory

Date

7/30/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

▶ Keith R. Dwyer

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC BREAST CARCINOMA

Approximate
Interval Between
Onset and Death

4 yr

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Virginia A. Dulany MD CMD

29c. License number

D33905

29d. Date signed (Month, Day, Year)

July 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIRGINIA A. DULANY MD, CMD

PO Box 2018 SALISBURY MD 21802

State
Registrar

31. Date filed (Month, Day, Year)

AUG 02 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


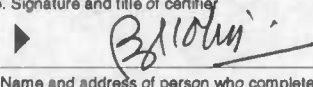

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26299

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Foster Petty, Jr.				2. Date of Death Month Day Year August 8, 2000				3. Time of Death 3:10 p.m.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 250-36-6816		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 10-27-1927		9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Charles		10c. City, Town or Location Bryans Road				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7305 Judi Drive				10f. Zip Code 20616		10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Explosive Ordnance Foreman				16b. Kind of Business/Industry United States Government		
17. Father's Name (First, Middle, Last) Richard Foster Petty, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Effie Phillips						
19a. Informant's Name/Relationship (Type, Print) Mary Frances Petty/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7305 Judi Drive, Bryans Road, Maryland 20616						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens				20c. Location - City or Town, State August 11, 2000 Waldorf, Maryland		
21. Signature of Funeral Service Licensee  M00668				22. Name and Address of Facility Williams Funeral Home, P.A. 20640 4270 Hawthorne Road, Indian Head, Maryland						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Congestive heart failure Due to (or as a consequence of): b. Severe Left Ventricular dysfunction Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic aortic failure, Hypertensive heart disease, Diabetes mellitus.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  MD				29c. License number D28035				29d. Date signed (Month, Day, Year) 08-09-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIR MOHAMMAD F. KOLTA M.D. 9135 Piscataway Rd. #210 CLINTON, MD 20735.										
State Registrar		31. Date filed (Month, Day, Year) AUG 10 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26300

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT THOMAS RUSSELL			2. Date of Death Month Day Year July 30 2000		3. Time of Death 1657
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER			4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 180-16-9862	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 29, 1923
	9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 401 Liberty St			10f. Zip Code 21804		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Shoe	
	17. Father's Name (First, Middle, Last) Robert Lance Russell			18. Mother's Name (First, Middle, Maiden Surname) Anna Lankford		
	19a. Informant's Name/Relationship (Type, Print) Karen Sue Russell/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Liberty St., Salisbury, MD 21804		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 7/31/00	20c. Location - City or Town, State Salisbury, MD
	21. Signature of Funeral Service Licensee David A. Thompson		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Congestive Heart Failure</u> Due to (or as a consequence of): b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death 2 months 4 yrs.						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Renal Failure 2° Nephrosclerosis</u> <u>Cardiac Arrhythmia</u>					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Benito S. Chan			
	29c. License number 0-20050		29d. Date signed (Month, Day, Year) 7/31/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENITO S. CHAN 5476 Riverside Dr. Salisbury MD 21804					
State Registrar	31. Date filed (Month, Day, Year) AUG 02 2000		32. Registrar's Signature B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 16b per F.D.
08/08/2000, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

00 26301

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillian Virginia Smith				2. Date of Death Month Day Year August 4, 2000		3. Time of Death 06:34a	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-07-3756	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 14, 1913		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Carroll	10c. City, Town or Location Woodbine			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7050 Old Washington Road			10f. Zip Code 21797		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector		16b. Kind of Business/Industry Clothing Industry Clothing Industry			
	17. Father's Name (First, Middle, Last) William Lucas				18. Mother's Name (First, Middle, Maiden Surname) Emma Childs			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Rash (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7050 Old Washington Road Woodbine, MD 21797			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Gardens		20c. Location - City or Town, State 8/7/2000 Glen Burnie, MD			
	21. Signature of Funeral Service Licensee Brian A. Haight		22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Right middle lobe pneumonia ~ 1-2 days Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA, HIDDEN						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier B. J. Sparks				29c. License number D 51705		29d. Date signed (Month, Day, Year) 8-4-2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANSURINA 419F Malcolm Dr, Westminster MD 21157							
31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature B. J. Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26302

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIA A. SMITH				2. Date of Death Month Day Year AUGUST 9 2000				3. Time of Death 3:55 AM	
	4a. Facility Name (If not institution, give street and number) Fort Washington Hospital				4b. City, Town, or Location of Death Ft. Washington				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 149-44-6971		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) OCT 30 1949		9. Birthplace (State or Foreign Country) Puerto Rico	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Accokeek				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 17919 Barney Drive				10f. Zip Code 20607		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Puerto Rican			14. Race - American Indian, Black, White, etc. Specify: Hispanic		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Key Tape Operator			16b. Kind of Business/Industry Library		
	17. Father's Name (First, Middle, Last) Carlos Melendez				18. Mother's Name (First, Middle, Maiden Surname) Maria Genaro					
	19a. Informant's Name/Relationship (Type, Print) John L. Smith (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17919 Barney Drive Accokeek, Maryland 20607					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		Data 8-12-00		20c. Location - City or Town, State Waldorf, MD			
	21. Signature of Funeral Service Licensee John H. Elmer M00173				22. Name and Address of Facility Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Hepatic failure Due to (or as a consequence of): b. Hepatic Sarcoidosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Chronic liver disease RENAL INSUFFICIENCY DIABETES MELLITUS				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Hawani Temesgen MD				29c. License number D46576		
29d. Data signed (Month, Day, Year) August 9, 2000										
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 6104 TEMPLE HILLS, MD 20748				31. Data filed (Month, Day, Year) 8/9/00				32. Registrar's Signature Beverly B. Sparks		
31. Data filed (Month, Day, Year) 8/9/00				32. Registrar's Signature Beverly B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Physician
/Medical
Examiner

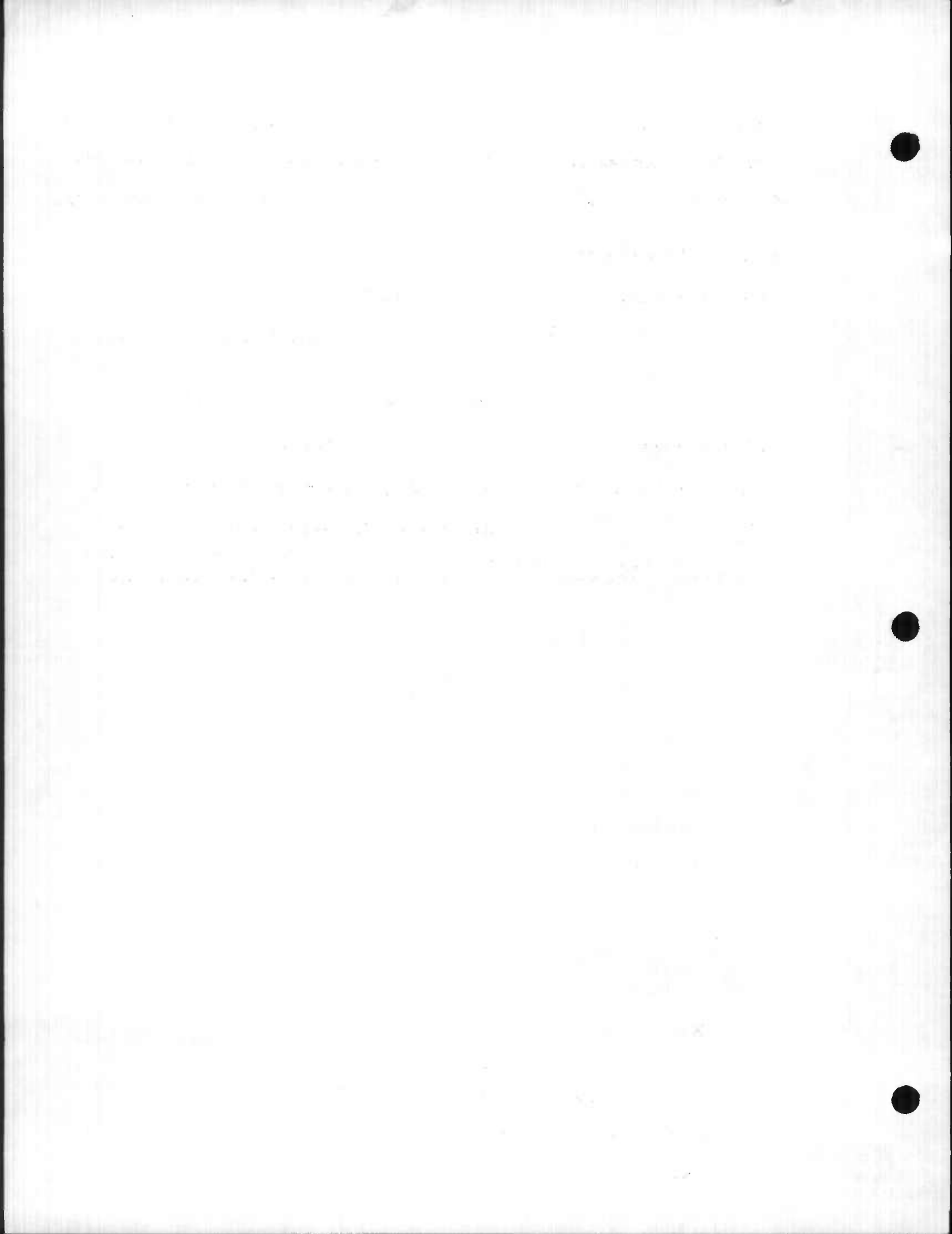
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26303

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOAN MARIE SMITH				2. Date of Death Month Day Year August 8 2000		3. Time of Death 12:15PM		
	4a. Facility Name (If not institution, give street and number) 2762 Pinewood Drive				4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles		
Funeral Director	5. Social Security Number 232-38-0418		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F XX		7. Age (In yrs. last birthday) 72		6. Date of Birth (Month, Day, Year) Dec. 2, 1927		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2762 Pinewood Drive		10f. Zip Code 20601		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) File Clerk Supervisor		16b. Kind of Business/Industry Federal Government F.B.I.					
17. Father's Name (First, Middle, Last) Ethan A. Cooper				18. Mother's Name (First, Middle, Maiden Surname) Maggie Ethel Saunders					
19a. Informant's Name/Relationship (Type, Print) Cecil R. Smith, Sr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2762 Pinewood Drive, Waldorf, Maryland 20601					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		Date 08-12-2000		20c. Location - City or Town, State Waldorf, Maryland			
21. Signature of Funeral Service Licensee JOHN P. KNISLEY M01164		22. Name and Address of Facility The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Non Hodgkins Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) XX <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier H. Mathur		29c. License number D28352		29d. Date signed (Month, Day, Year) August 8, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646									
31. Date filed (Month, Day, Year) AUG 10 2000		32. Registrar's Signature G. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Kaprice D. Solomon

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,pt.27,per me G788 10/25/00 yf

Certificate of Death

Reg. No. 00 26304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)
Baby Kaprice D. Solomon

2. Date of Death
Month Day Year
August 09, 2000 9:30 am

3. Time of Death

4a. Facility Name (If not institution, give street and number)
Civista Medical Center

4b. City, Town, or Location of Death
La Plata

4c. County of Death
Charles

5. Social Security Number
215-57-1676

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
Yrs. Months Days
6

8. Date of Birth (Month, Day, Year)
February 6, 2000

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County
Charles

10c. City, Town or Location
Pomfret

10d. Inside City Limits
☒ Yes 2 ☐ No

10e. Street and Number
4966 Preston Lane

10f. Zip Code
20675

10g. Citizen of What Country?
USA

11. Marital Status
1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) Baby

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Baby

16b. Kind of Business/Industry
Baby

17. Father's Name (First, Middle, Last)
Ramon Solomon

18. Mother's Name (First, Middle, Maiden Surname)
Akakia Solomon

19a. Informant's Name/Relationship (Type, Print)
Akakia Solomon- mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4966 Preston Lane Pomfret, Maryland 20675

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery

20c. Location - City or Town, State
9/16/00 Brandywine, Maryland

21. Signature of Funeral Service Licensee
M00191

22. Name and Address of Facility
Adams Funeral Home P.A. Aquasco, Maryland 20608

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME (SIDS)
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
Stephen S. Radentz, MD

29c. License number
O.C.M.E.

29d. Date signed (Month, Day, Year)
August 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)
AUG 14 2000

32. Registrar's Signature
B. Sparks

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26305

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Sprankle

2. Date of Death

Month
JulyDay
24Year
2000

3. Time of Death

2215

4a. Facility Name (If not institution, give street and number)

Rt. 290 & 300

4b. City, Town, or Location of Death

Sudlersville

4c. County of Death

Queen Anne

Funeral
Director

5. Social Security Number

210-28-3400

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept 23, 1936

9. Birthplace (State or Foreign Country)

Penna.

Usual Residence of Decedent

10a. State

PA

10b. County

Blair

10c. City, Town or Location

Tyrone

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RD 4 Box 202

10f. Zip Code

16686

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Clair O'Shell

18. Mother's Name (First, Middle, Maiden Surname)

Flora Gummo

19a. Informant's Name/Relationship (Type, Print)

Judy Dean- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RD5, Box 34, Tyrone, Pa. 16686

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Eastlawn Cemetery

Data

20c. Location - City or Town, State

Tyrone

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, MD 2162023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IMMEDIATE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

7-24-00

28b. Time of
Injury

11:24 P M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

M.V.A.

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Road

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Rt 290 & 300

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0005754

29d. Date signed (Month, Day, Year)

7. 25. 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ralph E. Libby, M.D., 204 Medical Center Road, Grasonville, MD 21638

31. Data filed (Month, Day, Year)

AUG 1 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26306

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA LILLIAN SMART

2. Date of Death

Month Day Year
JULY 31, 2000

3. Time of Death

2358

Funeral
Director

4e. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

221-05-2778

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 24, 1916

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

DELMAR

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

RT 2 BOX 17

10f. Zip Code

19940

10g. Citizen of What Country?

AMERICA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

GEORGE POWELL

18. Mother's Name (First, Middle, Maiden Surname)

NINA ELLIS

19a. Informant's Name/Relationship (Type, Print)

SAMUEL SMART

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 353 DELMAR, DELAWARE 19940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BLADES CEMETERY

Date

8/5/00

20c. Location - City or Town, State

BLADES, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WATSON-YATES FUNERAL HOME, INC.
SEAFORD, DELAWARE 1997323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CAD

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

COPD

DM

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Michael Morrison

29c. License number

D32014

29d. Date signed (Month, Day, Year)

8/1/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHESH MOONDERA 106 WILFORD ST 504B SALISBURY MD 21804.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

LAURA SMART
221-05-2778

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26307

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES WILLIAM STEWART				2. Date of Death Month Day Year July 28 2000		3. Time of Death 22:53
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 217-24-3705	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 4, 1930	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 606 Douglas Road				10f. Zip Code 21801		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Realtor		16b. Kind of Business/Industry Real Estate	
17. Father's Name (First, Middle, Last) Charles S. Stewart				18. Mother's Name (First, Middle, Maiden Surname) Catherine (unknown)			
19a. Informant's Name/Relationship (Type, Print) Patricia F. Stewart/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Douglas Rd., Salisbury, MD 21801			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 7/30/00		20c. Location - City or Town, State Salisbury, MD	
21. Signature of Funeral Service Licensee Keith R. Drury				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD Due to (or as a consequence of): b. Cardiac Arrhythmia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and Title of certifier [Signature] DO				29c. License number A54827		29d. Date signed (Month, Day, Year) 7/29/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURIEL GIBSON, DO 106 WILFORD ST SUITE 207 SALISBURY MD 21804							
31. Date filed (Month, Day, Year) AUG 02 2000				32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26308

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Edward Skipper, Jr.				2. Date of Death Month: July Day: 26 Year: 2000		3. Time of Death 1120	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 218-28-7942	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth 09/14/1932	9. Birthplace (State or Foreign Country) USA	
	Usual Residence of Decedent							
10a. State DE		10b. County Sussex		10c. City, Town or Location Laurel		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 107 Tracey Circle				10f. Zip Code 19956		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 7 College (1-4 or 5+): 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fuel Handler		16b. Kind of Business/Industry Fuel		
17. Father's Name (First, Middle, Last) Joseph Edward Skipper				18. Mother's Name (First, Middle, Maiden Surname) Alice Hyson Skipper				
19a. Informant's Name/Relationship (Type, Print) Dolores Skipper/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Tracey Circle Laurel, DE 19956				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Delaware Veterans Cem.		20c. Location - City or Town, State 7-28-2000 Millsboro, DE		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Short Funeral Home 700 West Street Laurel, DE 19956				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of): b. <u>CONGESTIVE HEART FAILURE</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 DAY 1 YEAR
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D29168		29d. Date signed (Month, Day, Year) 7/26/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Allen, M.D., 500 RIVERSIDE DR. A204 SALISBURY, MD								
31. Date filed (Month, Day, Year) JUL 27 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26309

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Elizabeth Thumlert				2. Date of Death Month Day Year July 27 2000		3. Time of Death 1540		
	4a. Facility Name (If not institution, give street and number) The Kent and Queen Anne's Hospital, Inc.				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent		
Funeral Director	5. Social Security Number 213-14-7117		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) September 12 1923		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5096 Edwards Lane		10f. Zip Code 21661		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home		17. Father's Name (First, Middle, Last) Leo Plummer		18. Mother's Name (First, Middle, Maiden Surname) Mary Wright	
19a. Informant's Name/Relationship (Type, Print) Carol Lee Spinoso				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10530 Old Court Road, Granite, Maryland 21163					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery		20c. Date 7/31/2000		20d. Location - City or Town, State Chestertown, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR TACHYCARDIA Due to (or as a consequence of): b. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death Minutes 24 hr.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE PREVIOUS CEREBROVASCULAR ACCIDENTS									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number DH1587		29d. Date signed (Month, Day, Year) 7/28/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble 122 Speer Road, Chestertown, Maryland 21620				31. Date filed (Month, Day, Year) AUG 1 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signatures and the text "Page 1" are visible at the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26310

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paula Thibault				2. Date of Death Month Day Year August 10, 2000		3. Time of Death 12:00 Noon	
	4a. Facility Name (If not institution, give street and number) Magnolia Hall Nursing Home				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 075-14-8799	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 8, 1915		9. Birthplace (State or Foreign Country) Philippines
	Usual Residence of Decedent							
10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 207 Rolling Road				10f. Zip Code 21620		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Programmer		16b. Kind of Business/Industry Computer		
17. Father's Name (First, Middle, Last) Lorenzo Thibault				18. Mother's Name (First, Middle, Maiden Surname) Elvira Paulsen				
19a. Informant's Name/Relationship (Type, Print) Glenn Dulmage				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Valley Road, Chestertown, Maryland 21620				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC 8/11/2000 Stevensville, Maryland		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of):								6 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. PERITONITIS Due to (or as a consequence of):								6 days
c. SUSPECTED ISCHEMIC BOWEL Due to (or as a consequence of):								10 days
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION DIABETES ADVANCED DEMENTIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D0041587		29d. Date signed (Month, Day, Year) 8/10/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble 122 Speer Road, Chestertown, Maryland 21620								
31. Date filed (Month, Day, Year) AUG 11 2000				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26311

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernice Elizabeth Turner				2. Date of Death Month Day Year August 2 2000		3. Time of Death 2:45 P.M.		
	4a. Facility Name (If not institution, give street and number) Magnolia Hall Nursing & Convalescent Home				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent		
Funeral Director	5. Social Security Number 212-10-9031		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/28/1928	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State MD		10b. County Kent		10c. City, Town or Location Chestertown			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 207 Lincoln Drive				10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) College (1-4or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic			16b. Kind of Business/Industry Private Families		
17. Father's Name (First, Middle, Last) David Johnson				18. Mother's Name (First, Middle, Maiden Surname) Irma Maker					
19a. Informant's Name/Relationship (Type, Print) Karen Turner - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Flatland Road, Chestertown, MD 21620					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Janes Cemetery		Date 8/7/00		20c. Location - City or Town, State Chestertown, MD 21620		
21. Signature of Funeral Service Licensee James A. Perkins				22. Name and Address of Facility James A. Perkins Funeral Service P. O. Box 143, 21106 Rock Hall Ave., Rock Hall MD 21661					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SUSPECTED ARRHYTHMIA Due to (or as a consequence of): b. HYPERTENSIVE CARDIOVASCULAR DISEASE >10 YRS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death < 1 min	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES ATRIAL FIBRILLATION PERIPHERAL VASCULAR DISEASE RENAL INSUFFICIENCY						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Jan A. Noble M.D.		29c. License number D0041587		29d. Date signed (Month, Day, Year) 8/4/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A Noble M.D. 122 Speer Rd Suite 5 CHESTERTOWN Md 21620									
31. Date filed (Month, Day, Year) AUG 4 2000			32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

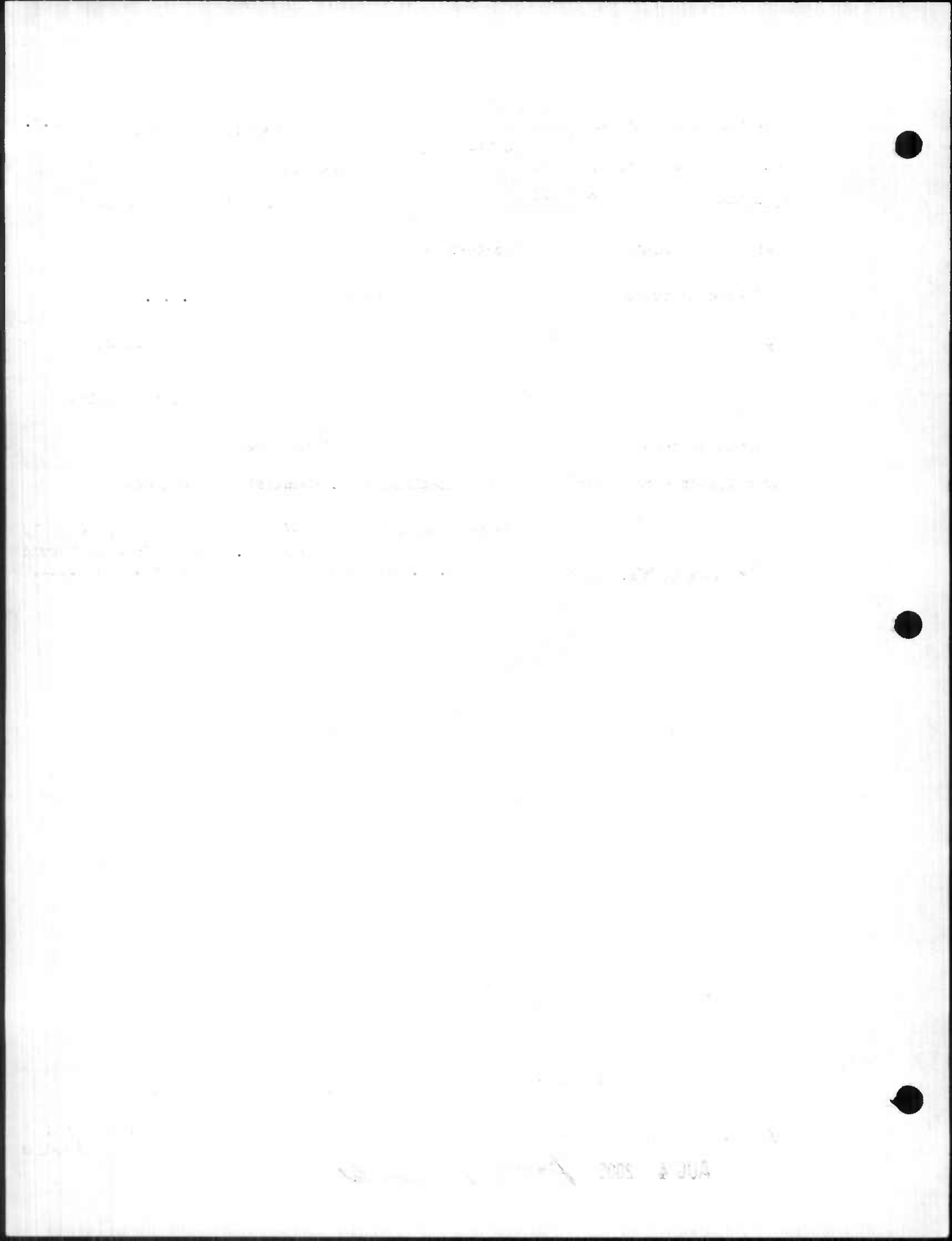
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26312

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Robert Willet				2. Date of Death Month Day Year August 5 2000		3. Time of Death 1550	
	4a. Facility Name (If not Institution, give street and number) 2644 Tyrone Road				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll County	
Funeral Director	5. Social Security Number 218-64-3456		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 4, 1953	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Carroll County		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2644 Tyrone Road		10f. Zip Code 21158	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) painting contractor				16b. Kind of Business/Industry painting		17. Father's Name (First, Middle, Last) Robert D. Willet	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Ethel R. Rill				19a. Informant's Name/Relationship (Type, Print) Nora A. Willet / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2644 Tyrone Road Westminster, Maryland 21158	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematorium		20c. Location - City or Town, State Smithsburg, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Alan C. Davis M01072				22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic colon CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 3 1/2 mos			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Flavio Kruter MD			
	29c. License number D35398				29d. Date signed (Month, Day, Year) 8-7-00			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter MD, 224 Washington Heights, Westminster, MD 21157				31. Date filed (Month, Day, Year) AUG 08 2000			
	32. Registrar's Signature B Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26313

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janet Helen Wolfe				2. Date of Death Month August Day 5 Year 2000		3. Time of Death 1910	
	4a. Facility Name (If not institution, give street and number) 4921 Feeser Road West				4b. City, Town, or Location of Death Taneytown		4c. County of Death Carroll County	
Funeral Director	5. Social Security Number 211-34-8012		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 2, 1945	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Carroll County		10c. City, Town or Location Taneytown	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 4921 Feeser Road West		10f. Zip Code 21787	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) shipping clerk				16b. Kind of Business/Industry publishing house			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Joseph Edward Krichten				18. Mother's Name (First, Middle, Maiden Surname) Bernadette Josephine Gephart			
	19a. Informant's Name/Relationship (Type, Print) Donald N. Wolfe/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4921 Feeser Road West Taneytown, MD 21787			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Keysville Union Cemetery		20c. Location - City or Town, State Aug. 9 2000 Keymar, Maryland	
	21. Signature of Funeral Service Licensee John M. Skiles M00534				22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC ADENOCARCINOMA						Approximate Interval Between Onset and Death 9 m	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)						28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and Title of certifier Flavio Kruder MD	
To Be Completed by Physician/Medical Examiner	29c. License number D35398						29d. Date signed (Month, Day, Year) 8-7-00	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Flavio Kruder MD 224 Washington Heights Westminster, MD 21157						31. Date filed (Month, Day, Year) AUG 08 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature Barbara S. Sparks						33. Date of Death Aug 5 2000	
	34. Time of Death 1910						35. County of Death Carroll County	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26314

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Elizabeth Wisner					2. Date of Death Month Day Year 08-03-2000		3. Time of Death 10:15 PM		
	4a. Facility Name (If not institution, give street and number) Genesis Randallstown					4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-30-6374		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 70		8. Data of Birth (Month, Day, Year) 07-16-30		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Boring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 14723 Old Hanover Road				10f. Zip Code 21020		10g. Citizen of What Country? US			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Insurance		
	17. Father's Name (First, Middle, Last) Carroll Elwood Palmer					18. Mother's Name (First, Middle, Maiden Surname) Margaret Elizabeth Poole				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert E Wisner SR, spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14723 Old Hanover Road, Boring, MD 21020				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion UMC		20c. Location - City or Town, State Upperco, MD		20d. Date 08-07		
	21. Signature of Funeral Service Licensee Daniel A. Payne					22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA Respiratory failure									
State Registrar	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Allen Hettleman					29c. License number DZ7569		29d. Date signed (Month, Day, Year) 8/4/08			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Hettleman 1838 Greene Tree Rd #300 Pikesville, MD 21208										
31. Date filed (Month, Day, Year) AUG 08 2000					32. Registrar's Signature B Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26315

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hugh Branham Williams

2. Date of Death

Month Day Year
August 4, 2000

3. Time of Death

0505 hrs

4a. Facility Name (If not institution, give street and number)

Kent and Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

027-28-2100

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 7, 1930

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Rock Hall

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

22520 Hudson Road

10f. Zip Code

21661

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 No

If Yes, Give

Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5 +

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Computer Programmer / Designer

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Charles Sumner Williams

18. Mother's Name (First, Middle, Maiden Surname)

Julia Branham

19a. Informant's Name/Relationship (Type, Print)

Gwyn Williams - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22520 Hudson Road, Rock Hall, Maryland 21661

20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Cremation Center LLC

Date

August 6, 2000

20c. Location - City or Town, State

Stevensville, Maryland

21. Signature of Funeral Service Licensed

William L. King, Jr. M-00937

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 X No

25. Was case referred to medical

examiner?

1 Yes 2 X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury et

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D005178

29d. Date signed (Month, Day, Year)

August 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Andrew Ferguson, 120 Speer Road, Suite 2, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

AUG 8 2000

32. Registrar's Signature

B. Sparks

12/1

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26316

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Holland Workman				2. Date of Death Month Day Year July 26, 2000				3. Time of Death 0555	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 221-18-8258	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 14, 1929		9. Birthplace (State or Foreign Country) DE		
	Usual Residence of Decedent									
10a. State MD		10b. County Somerset		10c. City, Town or Location Princess Anne				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 30512 Nutter's Lane				10f. Zip Code 21853		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-52		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 years College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver			16b. Kind of Business/Industry Transportation			
17. Father's Name (First, Middle, Last) Robert Atlas Workman				18. Mother's Name (First, Middle, Maiden Surname) Margie Hill Workman						
19a. Informant's Name/Relationship (Type, Print) Robert H. Workman, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 38 Eden, MD 21822						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Hill Memory Gardens		Date 7/29/00		20c. Location - City or Town, State Hebron, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, DE						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Perforated viscous & septic shock Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prior stroke, MI										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number D33796		29d. Date signed (Month, Day, Year) 7/26/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID WALKER, M.D. PRMC 100 E CAYALL ST. SALISBURY, MD. 21801										
31. Date filed (Month, Day, Year) JUL 27 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26317

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley D. Barnes Jr.				2. Date of Death Month AUGUST Day 16 , Year 2000		3. Time of Death 2140 PM		
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NA		
Funeral Director	5. Social Security Number 214-92-4390	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) MARCH 31 1971	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 711 Bartlett Ave			10f. Zip Code 21218		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry Restaurant			
	17. Father's Name (First, Middle, Last) Stanley D. Barnes Sr				18. Mother's Name (First, Middle, Maiden Surname) Norene R. Thomas				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name Relationship (Type, Print) Norene R. Thomas mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Gwynn Oak Ave Balt. MD 21207						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial		20c. Location - City or Town, State Baltimore, MD				
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Wylee Funeral Home PA 688 N. Calver ST. Balt. MD 21217						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE GUNSHOT WOUNDS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month; Day Year) 8/16/00		28b. Time of Injury 9:00 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT WAS SHOT	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number OCME		29d. Date signed (Month, Day, Year) AUGUST 17, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS MD, 111 Penn Street, Baltimore, Maryland 21201									
State Registrar	31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26318

AMEND#7 PER F.H. G786 8-21-2000 JAB

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEROY BETHEA

2. Date of Death

8 16 2000

3. Time of Death

8:20 P.M.

4a. Facility Name (If not institution, give street and number)

1718 E. 29th St

4b. City, Town, or Location of Death

Balt.

4c. County of Death

N.A.

Funeral
Director

5. Social Security Number

242 24 6988

6. Sex

M 20 F

7. Age (In yrs. last birthday)

72 73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8/21/27

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

N.A.

10c. City, Town or Location

Balt.

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1718 E. 29th St

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

Koppers Co.

17. Father's Name (First, Middle, Last)

JAMES MANUEL Bethea

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE McHERN

19a. Informant's Name/Relationship (Type, Print)

Patricia Bethea

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5611 Bellerillo Ave Balt. Md

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baroness Forest Cmn

Date

8/22/00

20c. Location - City or Town, State

Gwynn Mills Md

21. Signature of Funeral Service Licensee

Joseph B. Lick

22. Name and Address of Facility

Joseph B. Lick 1304 N. Central Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

TERMINAL CARDIAC ARRHYTHMIA

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

ACUTE MYOCARDIAL ISCHEMIA

b.

Due to (or as a consequence of):

CORONARY ARTERIOSCLEROSIS

c.

Due to (or as a consequence of):

HYPERTENSIVE CARDIOVASCULAR DISEASE

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASTHMATIC BRONCHITIS

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph D. Notarangelo M.D.

29c. License number

D07316

29d. Date signed (Month, Day, Year)

AUG-17-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH D. NOTARANGELO M.D., 301 ST. PAUL PLACE BALTIMORE 21202

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

James P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

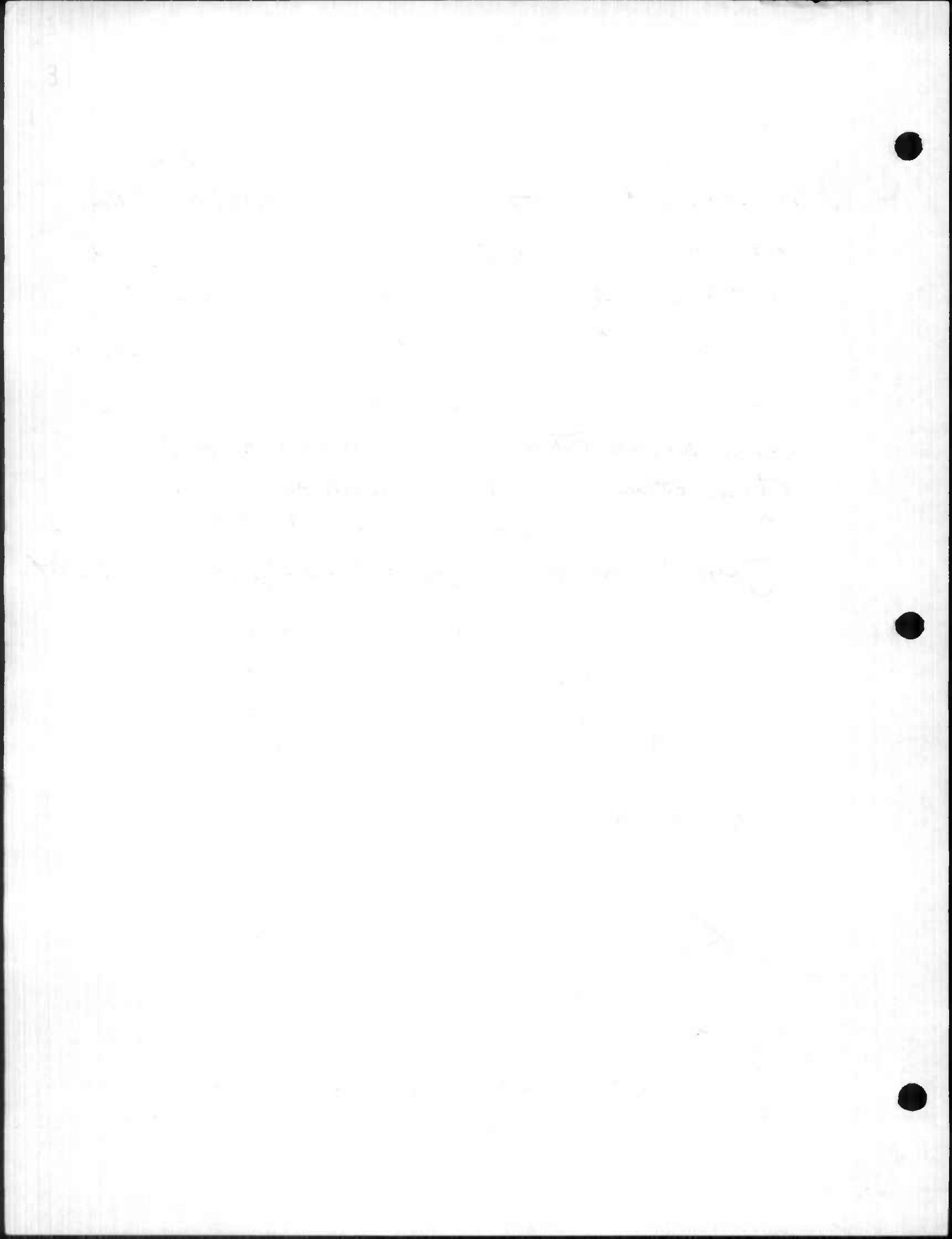
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26319

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>DOROTHY BADART</i>				2. Date of Death Month <i>August</i> Day <i>16</i> Year <i>2000</i>		3. Time of Death <i>12:30 AM</i>								
	4a. Facility Name (If not institution, give street and number) <i>Keswick Multicare</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>								
Funeral Director	5. Social Security Number <i>212.01.1605</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>92</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov. 30, 1907</i>								
	9. Birthplace (State or Foreign Country) <i>Colorado</i>		10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>								
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <i>700 W. 40th Street</i>				10f. Zip Code <i>21211</i>		10g. Citizen of What Country? <i>U.S.A.</i>								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Executive Secretary</i>		16b. Kind of Business/Industry <i>Construction</i>										
	17. Father's Name (First, Middle, Last) <i>Ferd Strouse</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Elizabeth Gibson</i>										
	19a. Informant's Name/Relationship (Type, Print) <i>Alexis Bodart/Brother in law</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Hill 6001 Old Lawyers Rd. Elkridge, MD 21075</i>										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Chesapeake Crematory</i>		20c. Location - City or Town, State <i>8/19 Beltsville, MD</i>										
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Gary L. Kaufman Funeral Home @ Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, Md. 21075</i>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Anemia</i></td> <td rowspan="4">Approximate Interval Between Onset and Death <i>6 days</i></td> </tr> <tr> <td>b. <i>Gastrointestinal bleeding</i></td> </tr> <tr> <td>c. <i></i></td> </tr> <tr> <td>d. <i></i></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Anemia</i>	Approximate Interval Between Onset and Death <i>6 days</i>	b. <i>Gastrointestinal bleeding</i>	c. <i></i>	d. <i></i>	
Immediate Cause (Final disease or condition resulting in death)	a. <i>Anemia</i>	Approximate Interval Between Onset and Death <i>6 days</i>													
	b. <i>Gastrointestinal bleeding</i>														
	c. <i></i>														
	d. <i></i>														
<table border="1"> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="2">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td></td> </tr> </table>								Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Advanced Alzheimer's disease</i>															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined															
28a. Date of Injury (Month, Day, Year) <i></i>															
28b. Time of Injury <i>M</i>															
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
28d. Describe how Injury occurred															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)															
28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <i>[Signature]</i>															
29c. License number <i>D13657</i>															
29d. Date signed (Month, Day, Year) <i>August 16, 2000</i>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MIRABELLE MAC GREGOR, KESWICK MULTICARE CENTER, BALTIMORE, MD 21211</i>															
31. Date filed (Month, Day, Year) <i>AUG 21 2000</i>															
32. Registrar's Signature <i>[Signature]</i>															

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26320

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PERCY ANDREW BROWN				2. Date of Death Month Day Year AUGUST 16 2000		3. Time of Death 7:00 A.M.		
	4a. Facility Name (If not institution, give street and number) 9126 BENGAL ROAD				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 218-48-0450		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 24, 1947		
	9. Birthplace (State or Foreign Country) GERMANY		10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location RANDALLSTOWN		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 9126 BENGAL ROAD		10f. Zip Code 21133		10g. Citizen of What Country? USA.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+HIGHER College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAREHOUSE SUPERVISOR		16b. Kind of Business/Industry LANDSCAPING CO.		17. Father's Name (First, Middle, Last) STERLING		18. Mother's Name (First, Middle, Maiden Surname) JONES ALICE JACKSON	
19a. Informant's Name/Relationship (Type, Print) YOLONDA BROWN (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 GILLAND COURT, NOTTINGHAM, MD. 21236		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		20c. Location - City or Town, State BALTO. MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Respiratory Failure Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 6/00			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D38662		29d. Date signed (Month, Day, Year) 8/18/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard S. Walsh 4660 Wilkens Ave. Baltimore MD 21229		31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26321

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Edwin Besore

2. Date of Death

August 18, 2000

3. Time of Death

8:20 a.m.

4a. Facility Name (If not institution, give street and number)

BROADMEAD

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-05-0628

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 30, 1908

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13801 York Rd.

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

1

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Allied Cordage Co.

17. Father's Name (First, Middle, Last)

Alpheus Neander Besore

18. Mother's Name (First, Middle, Maiden Surname)

Blanch Mills

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jessie H. Besore /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13801 York Rd. Apt. L-2 Cockeysville, Md. 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

8/19/00

20c. Location - City or Town, State

Towson, Md. 21204

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Right Frontal Intracerebral Bleed 2mo.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia
COPD
multi-infarct dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Barbara Carroll, MD

29c. License number

D38392

29d. Date signed (Month, Day, Year)

8/18/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA CARROLL, M.D., 13801 York Rd., Cockeysville, MD 21030

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Barbara Carroll

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

ADH

MICHAEL BERTI

00-4666-510

AMEND ITEMSL #23 PART I, 27, 28A-F

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PER MEO G786 8-28-00 WR.

Certificate of Death

Reg. No.

00 26323

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Anthony Berti

2. Date of Death

Month

Day

Year

AUGUST

17, 2000

3. Time of Death

2110 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6201 EUNICE AVENUE

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

218-74-9718

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 22, 1972

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6201 Eunice Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Barber Shop

17. Father's Name (First, Middle, Last)

Joseph Anthony Berti

18. Mother's Name (First, Middle, Maiden Surname)

JoAnne Norton

19a. Informant's Name/Relationship (Type, Print)

JoAnne Dehaghi- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6201 Eunice Avenue Baltimore, Maryland 21214

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oaklawn Cemetery

Date

8/21/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

AT SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☒ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

8-17-00
Found:

28b. Time of Injury

9:00 PM
Found:

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject
ingested drugs & alcohol28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Found AT HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

BALTIMORE, MARYLAND

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TITUS, M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

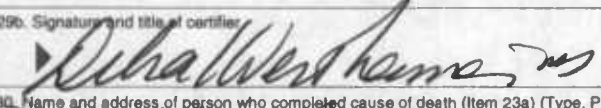

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26324

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JEAN BALBOS				2. Date of Death AUG 16 2000		3. Time of Death 5AM	
	4a. Facility Name (If not institution, give street and number) LEVINDALE NURSING HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 053-16-6337		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 9/21/1921	
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 7503 PARK HEIGHTS AVE				10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) JOSEPH LEVY				18. Mother's Name (First, Middle, Maiden Surname) IDA (UNKNOWN)			
	19a. Informant's Name/Relationship (Type, Print) INA DREIBAND/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 VELVET VALLEY WAY, OWINGS MILLS, MD. 21117			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW YOUNG MEN		20c. Location - City or Town, State 8/18/00 BALTIMORE, MD.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD-PIKESVILLE, MD. 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Renal Failure years Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease years Due to (or as a consequence of): c. Diabetes years Due to (or as a consequence of): d. Pressure Sores years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number D23767		29d. Date signed (Month, Day, Year) August 17, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debra S Wertheimer MD, 2434 W. Belvedere Ave, Baltimore MD 21215							
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #20B, 22 PER F.H. G/86 8-19-00 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26325

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Blackmon		2. Date of Death Month August Day 17 Year 2000		3. Time of Death 6:29 AM
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 219-40-8773	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 10 19 43		9. Birthplace (State or Foreign Country) South Carolina		
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 424 E. Federal Street		10f. Zip Code 21202		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry BWI
	17. Father's Name (First, Middle, Last) Rufus Blackmon		18. Mother's Name (First, Middle, Maiden Surname) Violet McCloud		
	19e. Informant's Name/Relationship (Type, Print) Denise Goodman - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 E. Federal Street Baltu. Md. 21202		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Vossell Cemetery MT. ZION CEMETERY		Date 8-21-2000
	20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee Jeff Miller		22. Name and Address of Facility Miller's Metropolitan Chapel 1639 N. BROADWAY Baltimore, Maryland			
Physician /Medical Examiner	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death One Day
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier Jeff Miller - MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) August 17, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hunter Clay Champion, MD 600 North Wootest Baltimore, MD 21287				
State Registrar	31. Date filed (Month, Day, Year) AUG 19 2000		32. Registrar's Signature [Signature]		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1944-45

6 5 4 3 2 1

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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Journal of Management Education 26(7)p. 809-824

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State of Maryland / Department of Health and Mental Hygiene

00 26326

Amended items# 1&23 per ME G786 8-21-00 WJJ

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Charlene M. Cross</u>				2. Date of Death Month <u>August</u> Day <u>9</u> Year <u>2000</u>		3. Time of Death <u>1235am</u>	
	4a. Facility Name (If not institution, give street and number) <u>Maryland General Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>NA</u>	
Funeral Director	5. Social Security Number <u>238-62-8346</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>59</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <u>08-20-40</u>	9. Birthplace (State or Foreign Country) <u>NC</u>	
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>1718 N. Bond Street</u>				10f. Zip Code <u>21213</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4 or 5+) <u>4yrs.</u>				15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Registered Nurses</u>			15b. Kind of Business/Industry <u>Private Duty</u>	
17. Father's Name (First, Middle, Last) <u>Charles Keck</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Katie Haywood</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Allan Cross</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1718 N. Bond Street Baltimore, Maryland 21213</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest VA Cem.</u>			Date <u>08-16-2000</u>		20c. Location - City or Town, State <u>Owings Mills MD</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Baltimore, Maryland 21202</u> <u>WM.C.March FH 1101 E. North Avenue</u>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Arterial Respiratory Distress Syndrome</u> <u>Respiratory Failure on Ventilator</u> Due to (or as a consequence of):								Approximate Interval Between Onset and Death
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>89381</u>		29d. Date signed (Month, Day, Year) <u>8/9/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Alan Rhoades, M.D. 40 Maryland General Hospital</u>								
31. Date filed (Month, Day, Year) <u>AUG 21 2000</u>		32. Registrar's Signature <u>[Signature]</u>						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26327

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Miclick Churchill				2. Date of Death Month Day Year AUG. 7, 2000		3. Time of Death 0603 AM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number Unknown		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 2 Yrs.		8. Date of Birth (Month, Day, Year) 11-17-97	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2623 Park Heights Terrance		10f. Zip Code 21215		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Child		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Child		16b. Kind of Business/Industry Child		17. Father's Name (First, Middle, Last) Michael Churchill		
18. Mother's Name (First, Middle, Maiden Surname) Cindy Hitchcock		19a. Informant's Name/Relationship (Type, Print) Patricia Jackson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 McCulloh Street Baltimore, Maryland 21217		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem.Pk. Cem.		20c. Date 08-10-2000		20d. Location - City or Town, State Randallstown, MD		21. Signature of Funeral Service Licensee <i>Bernard E. Johnson</i>		
22. Name and Address of Facility Baltimore, Maryland 21202		22. Name and Address of Facility WM.C.March FH 1101 E. North Avenue		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Smoke Inhalation		Approximate Interval Between Onset and Death		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/7/00		28b. Time of Injury UNK M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred victim of house fire		28e. Location (Street and Number or Rural Route Number, City or Town, State) 2623 Park Heights Terr.		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier <i>Bernard E. Johnson</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 7, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201		
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature <i>B. Sparks</i>		33. State Registrar MD		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		



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State of Maryland / Department of Health and Mental Hygiene

00 26328

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janis G. Costell				2. Date of Death Month Day Year August 17, 2000				3. Time of Death 7:30 pm				
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 215-62-6554		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 10, 1951		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent				10a. State Maryland				10b. County Howard		10c. City, Town or Location Columbia		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 8698 Open Meadow Way				10f. Zip Code 21045		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mortgage Banker				16b. Kind of Business/Industry Banking				
	17. Father's Name (First, Middle, Last) Joseph Goodwin				18. Mother's Name (First, Middle, Maiden Surname) Virginia Hawkins								
	19a. Informant's Name/Relationship (Type, Print) Tom Costell / spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8698 Open Meadow Way Columbia, MD. 21045								
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date Aug. 21 2000		20c. Location - City or Town, State Catonsville, Maryland						
	21. Signature of Funeral Service Licensee Shirley Collins - Witzke				22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043				Approximate Interval Between Onset and Death years				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cirrhosis of the liver Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Anthony Riley, MD		29c. License number D25205		29d. Date signed (Month, Day, Year) August 18, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, GPRC 6701 N. Charles St. Balto. MD 21204													
31. Date filed (Month, Day, Year) AUG 21 2000		Registrar's Signature [Signature]											

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 26329

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martin John Christ				2. Date of Death Month Day Year August 19, 2000		3. Time of Death 2:20pm						
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 214-01-0877		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 3/1/12						
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Overlea						
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 433 Old Home Road		10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Steel Mill									
17. Father's Name (First, Middle, Last) Alphonse Christ				18. Mother's Name (First, Middle, Maiden Surname) Johanna Goheen									
19a. Informant's Name/Relationship (Type, Print) Linda Adamczyk (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 S. Stuart Street Balto., Maryland 21221									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other, place) Bel Air Memorial		20c. Location - City or Town, State Bel Air, Maryland		20d. Date 8/22/00							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221									
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Cardio-Pulmonary Arrest</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Cerebral Hemorrhage</td> </tr> <tr> <td>c. Post op Carotid Endarterectomy (RT)</td> </tr> <tr> <td>d. Severe Carotid Stenosis RT.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Cardio-Pulmonary Arrest	Approximate Interval Between Onset and Death	b. Cerebral Hemorrhage	c. Post op Carotid Endarterectomy (RT)	d. Severe Carotid Stenosis RT.
Immediate Cause (Final disease or condition resulting in death)	a. Cardio-Pulmonary Arrest	Approximate Interval Between Onset and Death											
	b. Cerebral Hemorrhage												
	c. Post op Carotid Endarterectomy (RT)												
	d. Severe Carotid Stenosis RT.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P STROKE Peripheral Vascular Disease.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier  MD		29c. License number D40121		29d. Date signed (Month, Day, Year) 8/21/00									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dale Buchbinder, M.D. 6569 N. Charles St., Baltimore, MD 21204													
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 											

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26330

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Agnes E. Corbin</i>				2. Date of Death Month Day Year <i>AUGUST 14 2000</i>		3. Time of Death <i>1:06 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>St. Agnes Health</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>419-05-0765</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>87</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>12-4-12</i>	
	9. Birthplace (State or Foreign Country) <i>VA</i>		10a. State <i>Md.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>2822 Belmont Ave</i>		10f. Zip Code <i>21216</i>	
	10g. Citizen of What Country? <i>U.S.A</i>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3rd</i> Collega (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Salesperson</i>				16b. Kind of Business/Industry <i>Hech + Company</i>			
	17. Father's Name (First, Middle, Last) <i>Andrew Curry</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Selawa Chin</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Agnes S. Brown-Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2822 Belmont Ave. Baltimore, Maryland 21216</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>			
	20c. Date <i>8-18-2000</i>				20d. Location - City or Town, State <i>Baltimore, Maryland</i>			
	21. Signature of Funeral Service Licenses <i>Jeff Miller</i>				22. Name and Address of Facility <i>Miller's Metropolitan Chapel, P.C. 1639 N. Broadway Baltimore, Md 21213</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): <i>years</i>				Approximate Interval Between Onset and Death			
Physician /Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease</i> <i>Anemia</i> <i>Cirrhosis</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <i>8-18-2000</i>			
	28b. Time of Injury <i>M</i>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Kevin H. Scrubbs MD</i>			
	29c. License number <i>038543</i>				29d. Date signed (Month, Day, Year) <i>August 17, 2000</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kevin H. Scrubbs MD 900 Caton Avenue Baltimore, Maryland 21219</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>AUG 19 2000</i>				32. Registrar's Signature <i>Denise B. Sparks</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 26331

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Wilmer D. Della</i>		2. Date of Death Month Day Year <i>AUGUST 16, 2000</i>		3. Time of Death <i>1954 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>UNION MEMORIAL HOSPITAL</i>		4b. City, Town, or Location of Death <i>BALTIMORE CITY</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>219-38-3781</i>	6. Sex <i>1 Male 2 Female</i>	7. Age (In yrs. last birthday) <i>57</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Dec. 4, 1942</i>
	9. Birthplace (State or Foreign Country) <i>MD</i>					
Usual Residence of Decedent						
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <i>1 Yes 2 No</i>
10e. Street and Number <i>319 LORRAINE AVE</i>				10f. Zip Code <i>21211</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 Yes 2 No</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 Yes 2 No</i>		14. Race - American Indian, Black, White, etc. <i>Specify: Black</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th grade</i> College (1-4or 5+) <i>n/a</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Box Maker</i>		16b. Kind of Business/Industry <i>Factory - Box Maker</i>		
17. Father's Name (First, Middle, Last) <i>Gilbert Della</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Margaret Baxsdate</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Phillips Swanne (sister)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3710 Woodridge Rd. Balt. Md. 21229</i>			
20a. Method of Disposition <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Voshell Ceme.</i>		20c. Location - City or Town, State <i>8/23/2000 Baltimore, MD.</i>		
21. Signature of Funeral Service Licensee <i>Funeral Home</i>		22. Name and Address of Facility <i>Beths Funeral Home 11294 - Caroline St. Balt. Md. 21213</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
23b. Did tobacco use contribute to the cause of death? <i>1 Yes 2 No 3 Probably 4 Unknown</i>						
24a. Was an autopsy performed? <i>INSPECTION</i> <i>1 Yes 2 No</i>						
24b. Were autopsy findings available prior to completion of cause of death? <i>1 Yes 2 No</i>						
25. Was case referred to medical examiner? <i>1 Yes 2 No</i>						
26. Place of Death (Check only one) Hospital: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>						
27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1 Yes 2 No</i>
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>						
29b. Signature and title of certifier <i>W.D. Della</i>		29c. License number <i>OCME</i>		29d. Date signed (Month, Day, Year) <i>AUGUST 17, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</i>						
31. Date filed (Month, Day, Year) <i>AUG 21 2000</i>		32. Registrar's Signature <i>Benjamin Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26332

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael

Thomas

Duncan

2. Date of Death

August

Day

17

Year

2000

3. Time of Death

10:25 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VA Medical Center, Fort Howard, Maryland

4b. City, Town, or Location of Death

Fort Howard

4c. County of Death

Baltimore

5. Social Security Number

479-38-2364

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 20 1938

9. Birthplace (State or Foreign Country)

South Dakota

Usual Residence of Decedent

10a. State

Iowa

10b. County

NA

10c. City, Town or Location

Sioux City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2115 Summit Street

10f. Zip Code

51104

10g. Citizen of What Country?

U.S. of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Proprietor

16b. Kind of Business/Industry

Music Store

17. Father's Name (First, Middle, Last)

Donald

Duncan

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy

Kelly

19a. Informant's Name/Relationship (Type, Print)

Virginia Duncan (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2115 Summit Street Sioux, Iowa 51104

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro

Date

August
21

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

W. Dabrowski-Chojnacki F.H.'s P.A.

1005 Dundalk Ave. Baltimore, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Malignant Melanoma with Metastasis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Aurora C. Tan, M.D.

29c. License number

D14958

29d. Date signed (Month, Day, Year)

August 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aurora C. Tan, M.D. 9600 North Point Road, Fort Howard, Maryland 21052

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

[Signature]

State
RegistrarAKA: Duncan, Michael T.
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26333
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathleen Nannett Davies				2. Date of Death Month August Day 17, Year 2000		3. Time of Death 11:25 AM	
	4a. Facility Name (If not institution, give street and number) 68 Shore Road				4b. City, Town, or Location of Death Edgemere		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-24-4777	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In y/s. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 15, 1927	9. Birthplace (State or Foreign Country) Edgemere, MD	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Edgemere			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 68 Shore Road				10f. Zip Code 21219		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+) File Clerk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) File Clerk		16b. Kind of Business/Industry Hospital		
17. Father's Name (First, Middle, Last) Adrian Frances				18. Mother's Name (First, Middle, Maiden Surname) Margaret Murphy				
19a. Informant's Name/Relationship (Type, Print) Mr. Gwilym A. Davies (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 68 Shore Road Edgemere, Maryland 21219				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 8/21/2000		20c. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <i>Metastatic Breast Cancer</i> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <i>2 1/2 yrs.</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):						
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>metastatic pleural involvement</i> <i>malignant pleural effusion</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.						
		29c. License number D54911		29d. Date signed (Month, Day, Year) 08-17-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodrigo B. Erlich - 4940 Eastern Ave. - A Building RM 112 Baltimore MD 21224								
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26334

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alfred Anthony Del Ciello		2. Date of Death Month Day Year AUGUST 16, 2000		3. Time of Death 11:05 P.M.	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-26-4711		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 40	
	8. Date of Birth (Month, Day, Year) Dec. 20, 1929		9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 8191 Mid Haven Road		10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (1-4 or 5+) 6 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tile Setter		16b. Kind of Business/Industry Union	
	17. Father's Name (First, Middle, Last) Alfred A. Del Ciello		18. Mother's Name (First, Middle, Maiden Surname) Rose M. Borrelli			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Susan Saverese (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1228 Willow Road Dundalk, Maryland 21222			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State Towson, Maryland	
20d. Date 8/18/2000						
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? INSPECTION 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201						
State Registrar	31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26335

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS DAVIS						2. Date of Death Month Day Year August 17, 2000		3. Time of Death 10:05am	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-78-2179		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 20, 1960		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State md.		10b. County Baltimore		10c. City, Town or Location Randallstown				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3711 Mc Donogh Road				10f. Zip Code 21133		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 2 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Preparer			16b. Kind of Business/Industry Restaurants		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Lewis Davis Jr.						18. Mother's Name (First, Middle, Maiden Surname) Ruth Dixon			
	19a. Informant's Name/Relationship (Type, Print) Ruth D. Davis - mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Mc Donogh Rd Randallstown, md. 21133			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Zion Cem		Date 8/23/00		20c. Location - City or Town, State Lansdowne, md.			
	21. Signature of Funeral Service Licensee Lewis T. Gwynn		22. Name and Address of Facility Lewis T. Gwynn Funeral Home		4517 Park Heights Ave. Baltto. md. 21215-6393					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Terminal Aspiration Due to (or as a consequence of): b. Calciphylaxis Due to (or as a consequence of): c. End Stage Renal Disease Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 10-15 min.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Klebsiella Peritonitis, History of Osteomyelitis (MRSA), Upper Gastrointestinal bleed, Hypertension, Diabetes Mellitus, Candidemia								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier [Signature]				29c. License number P14271		29d. Date signed (Month, Day, Year) August 17, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryam Kashi, MD 2401 W. Belvedere Ave. Baltimore MD 21215									
	31. Date filed (Month, Day, Year) AUG 19 2000		32. Registrar's Signature [Signature]							

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1900

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State of Maryland / Department of Health and Mental Hygiene

00 26336

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara R. Eslinger				2. Date of Death Month Day Year August 14 2000		3. Time of Death 11:10 PM		
	4a. Facility Name (If not institution, give street and number) 187 9th Street				4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 216-70-2505	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 28 1938		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasadena			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 187 9th Street			10f. Zip Code 21122		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping			16b. Kind of Business/Industry Nursing Home			
	17. Father's Name (First, Middle, Last) Louis Cantler				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Ritchie				
	19a. Informant's Name/Relationship (Type, Print) Rose Garces (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Stonegate Rd., Waukegan Ill. 60087				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro. Crematory, Inc.		Date Aug. 18 2000		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122				
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 yrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D14571		29d. Date signed (Month, Day, Year) 8/15/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Thomas Folkemer, M.D. 4231 Postal Court, Pasadena, MD. 21122									
State Registrar	31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature 				

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State of Maryland / Department of Health and Mental Hygiene

00 26337

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sallie Foster				2. Date of Death Month 8 Day 16 Year 2000		3. Time of Death 10:15 pm	
	4a. Facility Name (If not institution, give street and number) Genesis Hamilton 6040 Harford Rd				4b. City, Town, or Location of Death Balto, MD		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-24-9732		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) July 5, 1921	
	9. Birthplace (State or Foreign Country) S.C.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3304 CHESTERFIELD AVE		10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) XRAY TECH		16b. Kind of Business/Industry HOSPITAL			
	17. Father's Name (First, Middle, Last) THOMAS MC COLLOUGH		18. Mother's Name (First, Middle, Maiden Surname) MATTIE EVANS					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DAISEY WHITE DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3304 CHESTERFIELD AVE - BALTO., MD. 21213			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PK		20c. Location - City or Town, State BALTIMORE, MD.		20d. Date 8/22/00	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee James A. Cromartie				22. Name and Address of Facility BETTS FUNERAL HOME			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CVA				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CVA				23d. Describe how injury occurred			
	23e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				23f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Date signed (Month, Day, Year) 8/18/00	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier James A. Cromartie			
	29c. License number D45475				29d. Date signed (Month, Day, Year) 8/18/00			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD REZA RAHMANA GENESIS HAMILTON				31. Date filed (Month, Day, Year) AUG 21 2000			
	32. Registrar's Signature James A. Cromartie				33. Date signed (Month, Day, Year) 8/18/00			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 26338

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL FRANK				2. Date of Death Month Day Year AUG. 12 2000		3. Time of Death 7:20AM	
	4a. Facility Name (If not institution, give street and number) FUTURE CARE- CHERRYWOOD NURSING HOME				4b. City, Town, or Location of Death REISTERSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 216-10-9633		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth Month Day Year APR. 18 1914	
	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location OWINGS MILLS		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ARTIST		16b. Kind of Business/Industry WINDOW DISPLAYS		
17. Father's Name (First, Middle, Last) HARRY FRANK				18. Mother's Name (First, Middle, Maiden Surname) MARY (UNOBTAINABLE)				
19a. Informant's Name/Relationship (Type, Print) MRS. SYLVIA FRANK/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 SPRINGWATER COURT APT. B, OWINGS MILLS, MD. 21117				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) OHEB SHALOM MEMORIAL PK 8/15/00		20c. Location - City or Town, State REISTERSTOWN, MD.		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Ischemic heart disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic stenosis s/p valve replacement								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number 027869		29d. Date signed (Month, Day, Year) 8/14/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Hettlerman 1838 Green Tree Rd #300								
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26339

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HILDA FISHER				2. Date of Death Month Day Year AUGUST 15 2000		3. Time of Death 16:18 PM	
	4a. Facility Name (If not institution, give street and number) 5643 PURDUE AVE. APARTMENT C				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-03-4527		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) 9/28/1918	
	9. Birthplace (State or Foreign Country) UNKNOWN		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 5643 PURDUE AVE APT. C		10f. Zip Code 21239		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (10-12) 12 Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INVESTIGATOR		16b. Kind of Business/Industry IRS				
17. Father's Name (First, Middle, Last) ARTHUR FISHER				18. Mother's Name (First, Middle, Maiden Surname) SARAH SENKER				
19a. Informant's Name/Relationship (Type, Print) JOHN D. CALLAN/ FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 LAKE DRIVE TOWSON, MD. 21286				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP		Data 8/18/00		20c. Location - City or Town, State BALTIMORE, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 16, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26340

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hasty Perry Allen Ford

2. Date of Death

Month

Day

Year

August

6

2000

3. Time of Death

9:05am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

577-48-3234

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 14, 1913

9. Birthplace (State or Foreign Country)

N. C.

Usual Residence of Decedent

10a. State

D. C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3357 Holmead Place, N. W.

10f. Zip Code

20010

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charlie Wilson Perry

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Lee Perry

19a. Informant's Name/Relationship (Type, Print)

James B. Allen - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 Beaumont Rd., Silver Spring, Md., 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland National

Date

8-11-00 Laurel, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John W. Latney Jr.

CC0348

22. Name and Address of Facility

Latney's Funeral Home, Inc.

3831 Georgia Ave., N. W., Wash., D.C., 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Myocardial Infarction

6 days

Due to (or as a consequence of):

a.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Atherosclerotic Cardiovascular Disease 10 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George C. Hajjar, Jr.

29c. License number

039550

29d. Date signed (Month, Day, Year)

8-6-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Hajjar, Jr. M.D. 4850 Forbes Blvd Lanham, Md 20706

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Ford, Hasty

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26341

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN W. FRANKLIN

2. Date of Death

Month Day Year
AUGUST 15 2000

3. Time of Death

4:15 am

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

214-26-0420

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

10

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
06-14-30

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22 DOWLING CIRCLE, #A1

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 TH GRADECollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

OTIS WHITE

18. Mother's Name (First, Middle, Maiden Surname)

Liz

19a. Informant's Name/Relationship (Type, Print)

ELMIRA GILES DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 DOWLING CIR., BALTO. MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

KING PARK CEMETERY

Date

8-18-00

20c. Location - City or Town, State

RANDAUSTOWN, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NAT'L PIKE, BALTO. MD. 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

14 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Gram negative sepsis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vaughn C. Greene MD

29c. License number

D 52628

29d. Date signed (Month, Day, Year)

8-15-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAREK SALKINI, 827 Linden AV. BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

AUG 19 2000

32. Registrar's Signature

James B. Spauls

State
Registrar

ORIGINAL

Franklin, Joan
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
202-334-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AM 07-11-1957

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26342

amend item 20a, 18 per fh G786 8/21/00 yg

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY E. GERHARDT

2. Date of Death

Month 8 Day 14 Year 00

3. Time of Death

8:15 p.m.

4a. Facility Name (If not institution, give street and number)

Buckingham's Choice

4b. City, Town, or Location of Death

Adamstown

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

218-32-5580

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month/Day/Year)

6/3/02

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

Frederick

10c. City, Town or Location

Adamstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3200 Bakers Circle

10f. Zip Code

21710

10g. Citizen of What Country?

Frederick

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Frank Gadow

18. Mother's Name (First, Middle, Maiden Surname)

Grace Hammer

19a. Informant's Name/Relationship (Type, Print)

Wayne Gadow /nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3303 Bountiful Dr. Westminster, Md. 21152

20a. Method of Disposition

1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

8/19/00

20c. Location - City or Town, State

Towson, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Rd Towson MD 21204
Buck Towson Funeral Home, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Coronary Artery Disease
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30496

29d. Date signed (Month, Day, Year)

8/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis E. Becker MD 300 W. 9th St; Frederick MD 21701

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

State
RegistrarGerhardt
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.


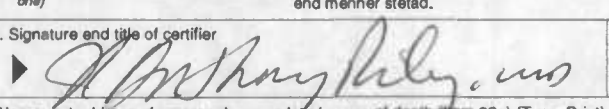
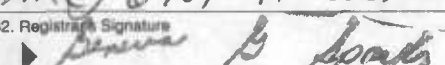
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26343

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID P. GORDON		2. Date of Death Month AUGUST Day 15 Year 2000		3. Time of Death 8:45 PM							
	4a. Facility Name (If not Institution, give street and number) GILCHRIST CENTER - HOSPICE OF BALTIMORE		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE							
Funeral Director	5. Social Security Number 215-18-6926	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.							
	8. Date of Birth (Month, Day, Year) 09/22/1914		9. Birthplace (State or Foreign Country) NEW YORK									
Usual Residence of Decedent												
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
10e. Street and Number 5 GREENLEA DRIVE			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: WHITE												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ATTORNEY		16b. Kind of Business/Industry LAW								
17. Father's Name (First, Middle, Last) CHARLES GORDON			18. Mother's Name (First, Middle, Maiden Surname) FRIEDA FUERSTEIN									
19a. Informant's Name/Relationship (Type, Print) MRS. VIRGINIA GORDON / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 GREENLEA DRIVE, BALTIMORE, MD 21208									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO CONG.		20c. Location - City or Town, State BALTIMORE, MD								
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. gangrene of foot</td> <td rowspan="4"> weeks </td> </tr> <tr> <td>b. peripheral vascular disease</td> <td rowspan="3"> years </td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. gangrene of foot	weeks	b. peripheral vascular disease	years	c.	d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. gangrene of foot	weeks										
	b. peripheral vascular disease		years									
	c.											
	d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ischemic cardiomyopathy												
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M								
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 		29c. License number 025205		29d. Date signed (Month, Day, Year) August 16, 2000								
30. Name and address of person who completed cause of death (from 23a) (Type, Print) W. A. Riley / GME 6701 N. Charles St. Balto. Md 21204												
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 										

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.David Gordon 8/15/00
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26344

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John D. Greene				2. Date of Death Month Day Year August 14, 2000		3. Time of Death 11:33 PM										
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's										
Funeral Director	5. Social Security Number 578-18-9364		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 4, 1920										
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State MD		10b. County Prince George's		10c. City, Town or Location Capitol Heights										
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 5005 Lee Jay Drive, #103		10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No N/A If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver		16b. Kind of Business/Industry Private												
	17. Father's Name (First, Middle, Last) John D. Greene, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Isabelle Dowe												
	19a. Informant's Name/Relationship (Type, Print) Marie Green-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 Lee Jay Dr., Capitol Heights, MD 20743												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Park		20c. Location - City or Town, State Laurel, MD												
	21. Signature of Funeral Service Licensee John W. Latney, Jr. CC0348		22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave., NW, Wash., DC 20011														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Advanced Dementia</td> <td>Approximate Interval Between Onset and Death Y/S</td> </tr> <tr> <td>b. Due to (or as a consequence of): Parkinson disease</td> <td>Y/S</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Advanced Dementia	Approximate Interval Between Onset and Death Y/S	b. Due to (or as a consequence of): Parkinson disease	Y/S	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)	a. Advanced Dementia	Approximate Interval Between Onset and Death Y/S														
b. Due to (or as a consequence of): Parkinson disease		Y/S															
c. Due to (or as a consequence of):																	
d. Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier N. J. Tavaroli, M.D.		29c. License number D41978		29d. Date signed (Month, Day, Year) 8-14-2000													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. J. Tavaroli, Hosp Dr Cheverly M.D. 20785																	
State Registrar	31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature [Signature]												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26345

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID GIBSON				2. Date of Death Month 08 Day 16 Year 2000		3. Time of Death 3:00 AM	
	4a. Facility Name (If not institution, give street and number) The Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 250321237		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) 09/23/1926	
	9. Birthplace (State or Foreign Country)		10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6228 Catalpa Avenue		10f. Zip Code 21214	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance				16b. Kind of Business/Industry HANES LINEBERRY Funeral Home		17. Father's Name (First, Middle, Last) WILLIE LEE GIBSON	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE WHITE				19a. Informant's Name/Relationship (Type, Print) IDA DRYGERS / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6228 Catalpa Avenue Baltimore, Md 21214	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Rest Cemetery		20c. Location - City or Town, State Towson, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility CHATHAM HARRIS Funeral Home 5240 RUSTENHURST ROAD BALTIMORE, MARYLAND 21211			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. sepsis Due to (or as a consequence of): d. G.I bleeding Approximate Interval Between Onset and Death 13 days 13 days 13 days 7 days				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier [Signature] Dr. Gao, MD				29c. License number P14417		29d. Date signed (Month, Day, Year) 8/16/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital				31. Date filed (Month, Day, Year) AUG 19 2000			
	32. Registrar's Signature [Signature]				33. Date of Death (Month, Day, Year) 08 16 2000			

ORIGINAL



7
2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26346

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David V. Hanna

2. Date of Death

Month Day Year
AUGUST 15, 2000

3. Time of Death

23:28 PM

4a. Facility Name (If not institution, give street and number)

OLD MILL PARK

4b. City, Town, or Location of Death

Millersville

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

214-06-9873

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

31 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 24 1969

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7861 Red Lion Way

10f. Zip Code

21122

10g. Citizen of What Country?

Anne Arundel

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Mexican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Heating & Air Condit.

17. Father's Name (First, Middle, Last)

James Hanna

18. Mother's Name (First, Middle, Maiden Surname)

Cruz Trevino

19a. Informant's Name/Relationship (Type, Print)

James Hanna (father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8086 Wolsey Court, Pasadena, Maryland 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro. Crematory, Inc.

Date

Aug 21 2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stallings Funeral Home, P.A.
3111 Mountain Road, Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hanging
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Found 8-15-2000 unknown Park

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Park

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Old Mill Park Anne Arundel County, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 16, 2000

30. Name and address of person who completed cause of death (If other than decedent) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a per PHYG786 8/21/2000 EW

Certificate of Death

Reg. No.

00 26347

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bartholomew F. Hines				2. Date of Death Month August Day 7 Year 2000		3. Time of Death 6:25 p.m.	
	4a. Facility Name (If not institution, give street and number) St. Joseph Manor 911 W. Lake Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 022-10-2490		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) April 4, 1917	
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 911 W. Lake Avenue		10f. Zip Code 21210		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5 +		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roman Catholic Priest		16b. Kind of Business/Industry Religion				
17. Father's Name (First, Middle, Last) Bartley Hines				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Costello				
19a. Informant's Name/Relationship (Type, Print) Fellow Very Rev. Robert Kearns, S.S.J./Priest				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street Baltimore, Maryland 21202				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery				
20c. Date 8/11/2000				20d. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee Michael E. Canapp				22. Name and Address of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): ARTERIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number D16006		29d. Date signed (Month, Day, Year) 8/8/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene E. Lauer 75050 Skokie Drive Towson MD								
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature [Signature]				

ORIGINAL

A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26348

AMND ITM#5 PE. F.H. G802 12-18-01 JAB

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL HAWKINS

2. Date of Death

August 15, 2000

3. Time of Death

2:40 AM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-48-2433

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 1, 1900

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

Maryland

10a. State

N/A

10b. County

Baltimore

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3701 Sequoia Ave

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Chamblin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Barnes

19a. Informant's Name/Relationship (Type, Print)

Dorothy Wilson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3701 Sequoia Ave Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

8/19/2000

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHARTMAN - HANSEN Funeral Home
5240 REISTERSTOWN RD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Mulla M.O

29c. License number

D0041410

29d. Date signed (Month, Day, Year)

August 15th, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P MEHTA
NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

AUG 19 2000

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

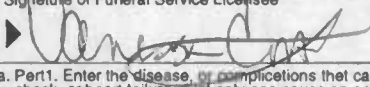
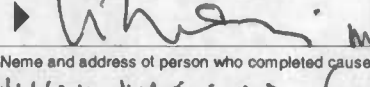

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26349

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT JONES		2. Date of Death Month August Day 16 Year 2000		3. Time of Death 7:45pm
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death NA
Funeral Director	5. Social Security Number 218-641973	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	8. Date of Birth (Month, Day, Year) 8-4-57	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent				
10a. State MD.		10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2626 Llewelyn Avenue			10f. Zip Code 21213	10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Improvement		16b. Kind of Business/Industry in & out of home	
17. Father's Name (First, Middle, Last) Benjamin Franklin Jones		18. Mother's Name (First, Middle, Maiden Surname) Cornelia Perrin			
19a. Informant's Name/Relationship (Type, Print) Danita Jones		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2626 Llewelyn Ave., Balto., Md. 21213			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem.		20c. Location - City or Town, State 08-22-2000 Arbutus, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYELOGENOUS LEUCEMIA					1 MONTH
Due to (or as a consequence of):					
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. ACUTE RENAL FAILURE					2 WEEKS
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  MD		29c. License number 053335		29d. Date signed (Month, Day, Year) August 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William W. Wolf, MD 600 N. Wolfe St. Baltimore, MD 21286					
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26350

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ida Black Jacobson

2. Date of Death

August 7 2000 PM

3. Time of Death

PM

4a. Facility Name (If not institution, give street and number)

5 Windmill Chase, Apt. G

4b. City, Town, or Location of Death

Sparks

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-20-6834

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 9, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Sparks

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Windmill Chase, Apt. G

10f. Zip Code

21152

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

George W. Black

18. Mother's Name (First, Middle, Maiden Summa)

Ida Mealy

19a. Informant's Name/Relationship (Type, Print)

Dorothea McDonnell/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33 Sugar Tree Pl., Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

8/14/00

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary per DVR

22. Name and Address of Facility

Lemon Funeral Home

10 W. Padonia Road, Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypertensive Atherosclerotic

Due to (or as a consequence of):

Cardio Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles F. O'Donnell MD

License number

D-09383

29c. Date signed (Month, Day, Year)

August 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD

111 Hamlet Hill Rd

Baltimore MD 21210

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Bryon B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, #3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#29d perPHYG786 8/21/2000 EW

Certificate of Death

Reg. No.

00 26351

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gilbert Johnson		2. Date of Death Month August Day 11TH Year 2000		3. Time of Death 4:30pm
	4a. Facility Name (If not institution, give street and number) Stella Maris - Mercy		4b. City, Town, or Location of Death Baltimore		4c. County of Death NA
Funeral Director	5. Social Security Number 212-08-1991	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 2-22-25		9. Birthplace (State or Foreign Country) West Indies		
Usual Residence of Decedent					
10a. State Md.		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1508 Abbotston St.		10f. Zip Code 21218		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labores		16b. Kind of Business/Industry Contractor	
17. Father's Name (First, Middle, Last) Levi Johnson		18. Mother's Name (First, Middle, Maiden Surname) Lila Mitchell			
19a. Informant's Name/Relationship (Type, Print) Bessie Johnson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Abbotston St., Balto., Md. 21218			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cem.		20c. Location - City or Town, State 8/18/00 Baltimore, Md.	
21. Signature of Funeral Service Licensee Lee Holland		22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiovascular Disease Diabetes Mellitus Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiovascular Disease Diabetes Mellitus		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dr. [Signature]		29c. License number D40854		29d. Date signed (Month, Day, Year) 8/12/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. [Signature] 301 St Paul Pl Baltimore 21202					
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26352

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Dorothy D. Jenkins</u>				2. Date of Death Month <u>August</u> Day <u>17</u> Year <u>2000</u>		3. Time of Death <u>10:15 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>SINAI HOSPITAL OF BALTIMORE</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>NA</u>	
Funeral Director	5. Social Security Number <u>218-14-9052</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>81</u> Yrs.		8. Date of Birth Month <u>April</u> , Day <u>4</u> , Year <u>1919</u>	
	9. Birthplace (State or Foreign Country) <u>VA</u>		10a. State <u>MD</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <u>3800 W. Belvedere Ave</u>		10f. Zip Code <u>21215</u>	
	10g. Citizen of What Country? <u>USA</u>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify <u>African American</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Packer</u>				16b. Kind of Business/Industry <u>Pharmacy</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>William A Jenkins Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Eleanor Burton</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Estelle Watkins daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1608 Lochwood Rd Baltimore MD 21218</u>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Arbutus Memorial</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>	
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Wynn Funeral Home</u> <u>638 N. Calver St. Baltimore, MD 21217</u>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>ACUTE MYOCARDIAL INFARCTION</u> Due to (or as a consequence of): b. <u>END STAGE RENAL DISEASE</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <u>G. E. Salumaa MD</u>				29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>August 17, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>GUNNAR E SALUMAA, MD</u>							
State Registrar	31. Date filed (Month, Day, Year) <u>AUG 21 2000</u>				32. Registrar's Signature <u>[Signature]</u>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26353

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marsha Klash

2. Date of Death

August 18 2000

3. Time of Death

0608

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Emergency Room

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

163-14-5576

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 4, 1917

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1401 North Lakewood Avenue, Apt 204

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

John

Klask

18. Mother's Name (First, Middle, Maiden Surname)

Anna

Falotko

19a. Informant's Name/Relationship (Type, Print)

Betty A. Veloz (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8423 Cocoa Road, Baltimore, Maryland 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

8/21/2000 Parkville, Maryland

21. Signature of Funeral Service Licensee

Robert C. Altenburg

22. Name and Address of Facility

Altenburg Funeral Home, P.A.
6009 Harford Road, Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 3 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jimmy Edmund M.D.

29c. License number

DS3124

29d. Date signed (Month, Day, Year)

August 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jimmy Edmund M.D. 4940 Eastern Ave, Baltimore, Maryland 21224

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Benjamin Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26354

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Tatsuko Kenealy				2. Date of Death Month Day Year AUG. 16, 2000		3. Time of Death 3:00 pm		
	4a. Facility Name (If not institution, give street and number) 7246 Montgomery Rd., Apt. B				4b. City, Town, or Location of Death Elkridge		4c. County of Death Howard		
Funeral Director	5. Social Security Number 212-46-5411		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 31, 1928		
	9. Birthplace (State or Foreign Country) Japan		10a. State MD		10b. County Howard		10c. City, Town or Location Elkridge		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7246 Montgomery Rd., Apt. B		10f. Zip Code 21075		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Caretaker		16b. Kind of Business/Industry Sisters of Trinity					
17. Father's Name (First, Middle, Last) Matuzero Okuno				18. Mother's Name (First, Middle, Maiden Surname) Shizu (Unavailable)					
19a. Informant's Name/Relationship (Type, Print) William E. Kenealy, Jr.-son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1452 B. Washington Ave., Severn, MD 21114					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 8/20		20c. Location - City or Town, State Beltsville, Md.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home 7250 Washington Blvd., Elkridge, MD 21075					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. End Stage COPD Due to (or as a consequence of): b. Abdominal Aortic Aneurysm Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 						29c. License number MD 22 102 (AC)	
		29d. Date signed (Month, Day, Year) 15 AUG 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nevins Johns Hopkins University - Meyer Bldg. 7th Flr.		31. Date filed (Month, Day, Year) AUG 21 2000						32. Registrar's Signature 	
State Registrar									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26355

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JACK RICH KINNEY				2. Date of Death Month Day Year 08 17 2000		3. Time of Death 8:22 AM	
	4a. Facility Name (If not institution, give street and number) BALTIMORE VETERANS ADMINISTRATION				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 267-56-7560		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) MAY 22, 1939	
	9. Birthplace (State or Foreign Country) Virginia		10a. State TN		10b. County Hancock		10c. City, Town or Location Eidson	
Usual Residence of Decedent		10e. Street and Number Rt. 1, Box 213B		10f. Zip Code 37731		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Soldier		16b. Kind of Business/Industry U.S. Armed Forces				
17. Father's Name (First, Middle, Last) Roy James Kinney				18. Mother's Name (First, Middle, Maiden Surname) Katherine Ledford				
19a. Informant's Name/Relationship (Type, Print) Sharon Kinney - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 213B, Eidson, TN 37731				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Castle Cemetery		20c. Date 8/22		20d. Location - City or Town, State Eidson, Tenn.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home 7250 Washington Blvd., Elkridge, Md. 21075				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		e. SEPSIS Due to (or as a consequence of):				Approximate Interval Between Onset and Death 24 hrs		
		b. PNEUMONIA Due to (or as a consequence of):				5 WEEKS		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. _____ Due to (or as a consequence of):						
		d. _____ Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number P12463		29d. Date signed (Month, Day, Year) 08/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kwabena Osei Boateng, 10 N. GREENE ST, BALTIMORE MD. 21209								
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26356

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Marie Kelley

2. Date of Death

Month Day Year
August 16, 2000

3. Time of Death

8:20 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

215.05.1879

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 18, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

503 Owens Way

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
4

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

C.M. Pitts

17. Father's Name (First, Middle, Last)

William Kelley

18. Mother's Name (First, Middle, Maiden Surname)

Dara Montgomery

19a. Informant's Name/Relationship (Type, Print)

Algerie Rae Eckart/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

503 Owens Way Severna Park, MD 21146

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Mem. Pk.

Date

8/18

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home
@ Meadowridge Mem. Park 7250 Washington Blvd
Elkridge, Maryland 2107523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Urinary tract infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypercalcemia, hyperkalemia, acute
renal failure, CHF

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide☐ Pending
Investigation
☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41816

29d. Date signed (Month, Day, Year)

8/16/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles W. Phelps MD Anne Arundel Medical Center

64 Franklin St.
Annapolis, MD 21401State
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26357

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Frances Korycki				2. Date of Death Month Day Year August 19 2000		3. Time of Death 4:15 Am		
	4e. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 232-30-7928	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 27, 1925		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 6664 Robert Court				10f. Zip Code 21061		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Household				
	17. Father's Name (First, Middle, Last) Jesse Mann				18. Mother's Name (First, Middle, Maiden Surname) Annie Maude Hawkins				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Beverly Rochford (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Johnson Road, Pasadena, MD 21122				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Date Aug. 22		20c. Location - City or Town, State Crownsville, MD		
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier [Signature] M.D.				29c. License number D51664		29d. Date signed (Month, Day, Year) AUGUST 19 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR KUMAR AGGARWAL NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061									
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature [Signature]					
State Registrar									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26358

Certificate of Death

Reg. No.

Physician Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth, Levickas				2. Date of Death Month August Day 18 Year 2000		3. Time of Death 7:00 PM	
	4a. Facility Name (If not institution, give street and number) St. Elizabeth Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-56-8881	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03/25/1914		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10e. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2200 Pleasantville Avenue				10f. Zip Code 21228		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse			16b. Kind of Business/Industry Health Care	
17. Father's Name (First, Middle, Last) Harry Brickerd				18. Mother's Name (First, Middle, Maiden Surname) Mary J. Vorack				
19a. Informant's Name/Relationship (Type, Print) Mary Carol Davis Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 Ebbwood Drive, Ellicott City MD 21042				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery		Date 8/21/00		20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue, Catonsville, Maryland 21228				
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Metastatic carcinoma to peritoneum and lung							6 months
	Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number D0055391		29d. Date signed (Month, Day, Year) August 18, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MING YI 210 Business Center Drive, Reisterstown, Maryland 21136								
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26359

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert Lilly			2. Date of Death Month Day Year Aug 18 2000		3. Time of Death 12:50 P.M.	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 243-07-9474		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 7, 1914
	9. Birthplace (State or Foreign Country) N. Carolina						
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2820 Presstman St.			10f. Zip Code 21216		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tailor		16b. Kind of Business/Industry Dry cleaning		
	17. Father's Name (First, Middle, Last) James Lilly			18. Mother's Name (First, Middle, Maiden Surname) Josie Lilly			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Antoinette Spence - great			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 Presstman St. Balto, MD. 21216			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD. National Mem. PK. B-22-00 Laurel, MD.		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility Grey P. March Funeral Home P.A. 270 Fredrickson Pass Balto, MD. 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. INTRACRANIAL BLEED Due to (or as a consequence of): b. ALZHEIMER'S DISEASE Due to (or as a consequence of): c. CONVULSIVE DISORDER Due to (or as a consequence of): d.			Approximate Interval Between Onset and Death 24 hrs. UNKNOWN UNKNOWN			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier [Signature] M.D.		29c. License number P12582		29d. Date signed (Month, Day, Year) AUGUST 18, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKSYMILIAN KAWALCZAK 800 CATION AVE, BALTIMORE, MD							
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26360

Amended items# 4a&24a per FH G787 9-6-00 WJJ

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSEMARY PATRICIA LOWERY				2. Date of Death Month 8 Day 12 Year 2000		3. Time of Death 1:40 pm	
	4a. Facility Name (If not institution, give street and number) 586 CYNWOOD DRIVE Hospice				4b. City, Town, or Location of Death EASTON		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 178-32-9919		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 26, 1916	9. Birthplace (State or Foreign Country) PA
	Usual Residence of Decedent							
10a. State Maryland		10b. County Talbot		10c. City, Town or Location Oxford			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 218B North Morris Street				10f. Zip Code 21654		10g. Citizen of What Country? U.S.A.		
11. Marital Status 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own home	
17. Father's Name (First, Middle, Last) Joseph Leo Galen				18. Mother's Name (First, Middle, Maiden Surname) Mane Marie Kerr				
19a. Informant's Name/Relationship (Type, Print) Fiona Foster/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 East Street, Oxford, MD 21654				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate interval Between Onset and Death
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. FULMINANT SEPSIS Due to (or as a consequence of):</p> <p>b. Lower Extremity GANGRENE Due to (or as a consequence of):</p> <p>c. Peripheral Vascular Disease Due to (or as a consequence of):</p> <p>d. CEREBROVASCULAR INSUFFICIENCY</p>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No				28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE				
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No
				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Eric Cidarek, MD				29c. License number D35048		29d. Date signed (Month, Day, Year) 8/12/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Cidarek, MD 2540 Centreville Road, Centreville, MD 21617								
31. Date filed (Month, Day, Year) AUG 16 2000				32. Registrar's Signature B. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, BALTIMORE, MD 21260

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

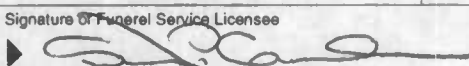
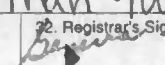
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26361

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES LANNEN				2. Date of Death Month August Day 16 Year 2000		3. Time of Death 12:37 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-38-5715		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 6, 1941	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2058 Jasmine Road		10f. Zip Code 21222		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking Industry		17. Father's Name (First, Middle, Last) Floyd Lannen		
18. Mother's Name (First, Middle, Maiden Surname) Sarah Love		19a. Informant's Name/Relationship (Type, Print) Mrs. Sally R. Lannen (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2058 Jasmine Road Dundalk, Maryland 21222		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Date 8/18/2000		20d. Location - City or Town, State Towson, Maryland		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.		22b. Address 7922 Wise Ave. Dundalk, Maryland 21222		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiomyopathy Due to (or as a consequence of):		Approximate Interval Between Onset and Death 4 years		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/16/00		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Stuart Ackerman		29c. License number RD 198796		29d. Date signed (Month, Day, Year) 8/16/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Stuart Ackerman 9000 Franklin Square Drive Baltimore, Maryland		31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 		21237		

LANNEN, CHARLES
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26362

Amended Items #7&8 per FD G786 8-21-00 WJJ

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN LIBOWITZ				2. Date of Death Month AUG Day 18 Year 2000		3. Time of Death 1:30PM		
	4a. Facility Name (If not institution, give street and number) 3330 CLARKS LANE APT. A				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-09-9147		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 - 79 Yrs.		8. Date of Birth (Month, Day, Year) JULY 18 1921		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3330 CLARKS LANE APT. A		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES		16b. Kind of Business/Industry RETAIL		17. Father's Name (First, Middle, Last) ISRAEL DONNER		18. Mother's Name (First, Middle, Maiden Surname) IDA CAPLIS	
19a. Informant's Name/Relationship (Type, Print) RALPH LIBOWITZ/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 CLARKS LANE APT. A BALTIMORE, MD 21215					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMUNO		Date 8/18/00		20c. Location - City or Town, State BALTIMORE, MD.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208					
23a. Part I: Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3 yrs							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D19317		29d. Date signed (Month, Day, Year) 8/16/00			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BORIS KERNER MD 1838 GREENTREE RD, BALTIMORE MD 21208									
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26363

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID LITTLE

2. Date of Death

Month Day Year
7 - 31 - 00

3. Time of Death

10:45 A.M.

4a. Facility Name (If not institution, give street and number)

NOBLE HOUSE 2327 N. CHARLES ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

245-20-1252

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 27, 1931

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2327 N. Charles Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Noble House

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2327 N. Charles St., Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in-state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPOPHARYNGEAL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D16619

29d. Date signed (Month, Day, Year)

August 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. VERGARA-SOARES 2327 N. CHARLES ST. BALTIMORE, MD 21218

State
Registrar

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26364

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Lewis				2. Date of Death Month Day Year 8/15/2000		3. Time of Death 7:15AM		
	4a. Facility Name (If not institution, give street and number) 4200 Necker Avenue				4b. City, Town, or Location of Death Nottingham		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 236-54-7615	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/28/34		9. Birthplace (State or Foreign Country) Trade, TN	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore		10c. City, Town or Location Nottingham			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 4200 Necker Avenue				10f. Zip Code 21236-2922		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates Vietnam Era		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years N/A			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Team Leader		16b. Kind of Business/Industry Bethlehem Steel			
	17. Father's Name (First, Middle, Last) James Christian Lewis				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Elaine Miller				
	19a. Informant's Name/Relationship (Type, Print) Margot Lewis (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4200 Necker Ave. Nottingham, Md 21236-2922				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		Date 8/19/00		20c. Location - City or Town, State Timonium, MD		
	21. Signature of Funeral Service Licensee E. J. Lassahn				22. Name and Address of Facility E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic adenocarcinoma of Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Janet Cooper MD				29c. License number D46118		29d. Date signed (Month, Day, Year) Aug 15, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET COOPER 1447 YORK Rd Lutherville MD 21093									
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature Beverly G. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26365

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD G. LEACH

2. Date of Death

Month Day Year
AUGUST 18 2000

3. Time of Death

11 05 PM

4a. Facility Name (If not institution, give street and number)

6 WALKWAY CT.

4b. City, Town, or Location of Death

MIDDLE RIVER

4c. County of Death

BALTO. MD.

Funeral
Director

5. Social Security Number

215-46-7162

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 21, 1947

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTO.

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 WALKWAY CT.

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

city of Baltimore

17. Father's Name (First, Middle, Last)

Solomon Leach

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Knapp

19a. Informant's Name/Relationship (Type, Print)

Linda Leach

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

899 Pine Knob RD. OSTERBURG P.A. 16667

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

8/21/00

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER Funeral Home CHD.
7527 HARTFORD RD. BALTO. MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic adenocarcinoma lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Brain metastases

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D96814

29d. Date signed (Month, Day, Year)

8/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard L. Hustig MD 9055 SUR DR. SUITE 302 Towson

31. Date filed (Month, Day, Year)

AUG 19 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26366

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Margaret Mooney</i>				2. Date of Death Month <i>Aug</i> Day <i>13</i> Year <i>2000</i>		3. Time of Death <i>11:01 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital of Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>327-24-0065</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>73</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>03 30 1927</i>	9. Birthplace (State or Foreign Country) <i>Illinois</i>	
	Usual Residence of Decedent								
10a. State <i>FL</i>		10b. County <i>Broward</i>		10c. City, Town or Location <i>Fort Lauderdale</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>2441 SW 82nd Avenue #102</i>				10f. Zip Code <i>33324</i>		10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher/Administrator</i>			16b. Kind of Business/Industry <i>Public School</i>		
17. Father's Name (First, Middle, Last) <i>Leslie Welsh</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Grant</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Thomas Mooney/Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>335 Wright St., #203 Lakewood, Colorado 80228</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mount Olivet Cemetery</i>		20c. Location - City or Town, State <i>08/23 Wheat Ridge, Co.</i>			
21. Signature of Funeral Service Licensee <i>Shubert Lewis</i>				22. Name and Address of Facility <i>Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Ave, Balto, Md 21228</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Sepsis</i> Due to (or as a consequence of): <i>necrotizing fasciitis</i> Due to (or as a consequence of): <i>Severe Immunocompromize</i> Due to (or as a consequence of): <i>leukemic</i>								Approximate Interval Between Onset and Death <i>1 day</i> <i>1 week</i> <i>1 year</i> <i>1 year</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>congestive heart failure</i> <i>severe mitral regurgitation</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and Title of certifier <i>SE LLC, MD</i>				29c. License number <i>RES 0000</i>		29d. Date signed (Month, Day, Year) <i>Aug 13 2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Sharmen Baubrook, MD 5101 Lamer Ave, Baltimore, MD 21215</i>									
31. Date filed (Month, Day, Year) <i>AUG 21 2000</i>				32. Registrar's Signature <i>Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26367

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James, Moniodis</u>				2. Date of Death Month <u>August</u> Day <u>19</u> Year <u>2000</u>		3. Time of Death <u>1:45 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Franklin Square Hospital Center</u>				4b. City, Town, or Location of Death <u>Rosedale</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>216-56-8871</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>49</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Feb. 22, 1951</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <u>9610 Trepid Road</u>				10f. Zip Code <u>21236</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>3</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Salesman</u>		16b. Kind of Business/Industry <u>Route</u>		
17. Father's Name (First, Middle, Last) <u>William James Moniodis</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Evangelia Hanakis</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Isabel Moniodis- Spouse</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9610 Trepid Road Baltimore, Maryland 21236</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>St. Demetrios</u>		Date <u>8/22/00</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>		
21. Signature of Funeral Service Licensee <u>Heather Cain</u> <u>Heather Cain</u>				22. Name and Address of Facility <u>Leonard J. Ruck, Inc.</u> <u>5305 Harford Road Baltimore, Maryland 21214</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Interstitial Pulmonary Fibrosis</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death <u>13 days</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sleep apnea, pneumonia</u> <u>obesity, diabetes mellitus</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>R. Gan Carden</u>				29c. License number <u>RD 803-372</u>		29d. Date signed (Month, Day, Year) <u>8/19/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>R. Gan Carden 9000 Franklin Square Drive Baltimore, Maryland</u>								<u>21237</u>
31. Date filed (Month, Day, Year) <u>AUG 21 2000</u>		32. Registrar's Signature <u>B. Sparks</u>						

ORIGINAL

278 EOG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26368

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY A. MEEHAN				2. Date of Death Month Day Year August 19, 2000				3. Time of Death 8:55 A.M.		
	4a. Facility Name (If not institution, give street and number) Golden Age Nursing Home				4b. City, Town, or Location of Death Sykesville				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 215-22-2196		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 104 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 22, 1895		9. Birthplace (State or Foreign Country) Ireland		
	10a. State N.Y.				10b. County Nassau		10c. City, Town or Location Bellmore				
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 2495 Beltagh Ave.				10f. Zip Code 11710		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Grade				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietitian				16b. Kind of Business/Industry Medical			
17. Father's Name (First, Middle, Last) Partick Mularkey				18. Mother's Name (First, Middle, Maiden Surname) Jane McGowan							
19a. Informant's Name/Relationship (Type, Print) Sandra L. Beynon Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4736 Sykesville Rd. Sykesville, Md. 21784							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rood Cemetery				Date 8/22/2000		20c. Location - City or Town, State Westbury, N.Y.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ELINE FUNERAL HOME				11824 Reisterstown Road Reisterstown, Md. 21136			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 25 years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D0051924		29d. Date signed (Month, Day, Year) August 18, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERBERT PAUL HENDERSON SR. GOLDEN AGE NURSING HOME											
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26369

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS NOVASH				2. Date of Death Month 08 Day 17 Year 2000		3. Time of Death 7:25 AM															
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death															
Funeral Director	5. Social Security Number 343-01-3058		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 26, 1917	9. Birthplace (State or Foreign Country) Maryland														
	Usual Residence of Decedent																					
10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
10e. Street and Number 600 Light Street, Apt. 818				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.																
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown																
17. Father's Name (First, Middle, Last) Samuel E. Plecker				18. Mother's Name (First, Middle, Maiden Surname) Eva Coleman																		
19a. Informant's Name/Relationship (Type, Print) Sally Heiberger/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11442 Glen Arm Road, Glen Arm, MD 21057																		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		20d. Date														
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility IIAM, 814 Cedar Avenue, Scranton, PA 18505																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. METASTATIC NON SMALL CELL CARCINOMA OF LUNG</td> <td>15 MONTHS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. PNEUMONIA</td> <td>1 MONTH</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. CONGESTIVE HEART FAILURE</td> <td>2 days</td> </tr> <tr> <td>d. SEPSIS</td> <td>2 days</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC NON SMALL CELL CARCINOMA OF LUNG	15 MONTHS	Due to (or as a consequence of):		b. PNEUMONIA	1 MONTH	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CONGESTIVE HEART FAILURE	2 days	d. SEPSIS	2 days
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC NON SMALL CELL CARCINOMA OF LUNG	15 MONTHS																				
	Due to (or as a consequence of):																					
	b. PNEUMONIA	1 MONTH																				
	Due to (or as a consequence of):																					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CONGESTIVE HEART FAILURE	2 days																				
	d. SEPSIS	2 days																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier G. Nimmagadda		29c. License number D39041		29d. Date signed (Month, Day, Year) August 17, 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAYATRI NIMMAGADDA 3001 S. Hanover Street Baltimore																						
31. Date of Death (Month, Day, Year) AUG 21 2000																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26370

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Willie Paige</i>		2. Date of Death Month <i>August</i> Day <i>17</i> Year <i>2000</i>		3. Time of Death <i>757pm</i>							
	4a. Facility Name (If not Institution, give street and number) <i>University of Maryland Medical System Baltimore</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>							
Funeral Director	5. Social Security Number <i>247-16-6265</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i> Yrs.	8. Date of Birth Month <i>March</i> Day <i>11</i> Year <i>1909</i>	9. Birthplace (State or Foreign Country) <i>S. Carolina</i>							
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	10e. Street and Number <i>301 N. Edgewood St.</i>		10f. Zip Code <i>21229</i>		10g. Citizen of What Country? <i>USA</i>							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5th</i> College (1-4 or 5+)									
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Foreman</i>		16b. Kind of Business/Industry <i>Maintenance</i>									
	17. Father's Name (First, Middle, Last) <i>John Paige</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Florence Gaddy</i>									
	19a. Informant's Name/Relationship (Type, Print) <i>Mary Paige - wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>301 N. Edgewood St. Balto., MD. 21229</i>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i>									
20c. Location - City or Town, State <i>Baltimore, MD.</i>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Gary E. March Funeral Home, P.A. 21229</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Respiratory Arrest</i></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <i>Aspiration Pneumonia</i></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)	a. <i>Respiratory Arrest</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. <i>Aspiration Pneumonia</i>	c.	d.
Immediate Cause (Final disease or condition resulting in death)	a. <i>Respiratory Arrest</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death									
	b. <i>Aspiration Pneumonia</i>											
	c.											
	d.											
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Colon Cancer</i> <i>Senile Dementia</i>												
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined												
28a. Date of Injury (Month, Day Year) <i>August 17, 2000</i>												
28b. Time of Injury <i>M</i>												
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
28d. Describe how Injury occurred												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <i>Michael E. Rolnick M.D.</i>												
29c. License number <i>D41396</i>												
29d. Date signed (Month, Day, Year) <i>August 18, 2000</i>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Michael E. Rolnick 22 South Bregans Street, Baltimore, Maryland 21201</i>												
31. Date filed (Month, Day, Year) <i>AUG 21 2000</i>												
32. Registrar's Signature <i>[Signature]</i>												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II 27 PER MEO G 186 8-22-00 WR.

Certificate of Death

Reg. No.

00 26371

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Laurence Warren Pyle			2. Date of Death Month August Day 13 Year 2000			3. Time of Death 08:14 A.M.				
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A				
Funeral Director	5. Social Security Number 216-42-4213		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 10, 1944		9. Birthplace (State or Foreign Country)		
	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 2023 Christian Street		10f. Zip Code 21223		10g. Citizen of What Country? USA							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator		16. Kind of Business/Industry Southern States							
17. Father's Name (First, Middle, Last) Francis William Pyle		18. Mother's Name (First, Middle, Maiden Surname) Ruth Dorothy Brooks									
19a. Informant's Name/Relationship (Type, Print) Michael Pyle- Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 Christian St. Baltimore, MD 21223									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Date 8/17/00		20d. Location - City or Town, State Beltsville, MD					
21. Signature of Funeral Service Licensee MSK Marshall		22. Name and Address of Facility Gary L. Kaufman Funeral Home 7250 Washington Blvd., Elkridge, MD 21075									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 14, 2000					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIPLEY, M.D.		31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, #9

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State of Maryland / Department of Health and Mental Hygiene

Amended items# 18&19a per FH G787 9-5-00 WJJ

Certificate of Death

Reg. No.

00 26372

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Isabel E. Peters				2. Date of Death Month Day Year August 18 2000				3. Time of Death 11:41 AM	
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Timonium				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-01-2297		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Feb. 6 1911		9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Timonium	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2300 Dulaney Valley Rd.				10f. Zip Code 21093	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Supervisor				16b. Kind of Business/Industry Hospital				17. Father's Name (First, Middle, Last) Michael Peters	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) WEIZELBERGER Mary Wetzolburger				19a. Informant's Name/Relationship (Type, Print) NAVARRE Mary Navarre/ Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Bayberry Rd. Edgewood, Md. 21040	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.				20c. Location - City or Town, State Baltimore, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee K. J. Laughry				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Dementia Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of Certifier Tariq Mahmood				29c. License number D43725	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) Aug. 18, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tariq Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093				31. Date filed (Month, Day, Year) AUG 21 2000	
	32. Registrar's Signature Benjamin S. Sparks				33. State Registrar AUG 21 2000				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26373

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Rebstock

2. Date of Death

August 17 2000

3. Time of Death

0040

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Agnes Hospital

4b. City, Town, or Location of Death

Baltimore, Maryland

4c. County of Death

N/A

5. Social Security Number

114-01-2847

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12 15 1906

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

721 Nottingham Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Factory

17. Father's Name (First, Middle, Last)

Richard F. Jupitz

18. Mother's Name (First, Middle, Maiden Surname)

Margarete L. Ebering

19a. Informant's Name/Relationship (Type, Print)

Elsie Jupitz/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

721 Nottingham Rd, Baltimore, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

08 19

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home, Inc

736 Edmondson Avenue, Balto, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypercapnic Hypoxemic Respiratory Failure

Due to (or as a consequence of):

b. Acute Pulmonary Edema

Due to (or as a consequence of):

c. Cardiogenic Shock

Due to (or as a consequence of):

d. Severe Mitral Regurgitation

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Hypertension

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shawn Beffall MD

29c. License number

P12599

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shawn Beffall Saint Agnes Hospital, 900 Canton Avenue, Baltimore Maryland

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Shawn Beffall

State Registrar

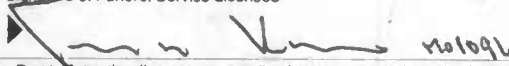
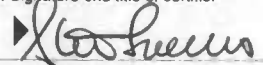
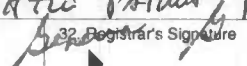
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26374

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herman S. Roemer				2. Date of Death Month August Day 20 Year 2000		3. Time of Death 5:45 pm	
	4a. Facility Name (If not institution, give street and number) Lorien Nursing Home				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 220-03-9094		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2929 Rosemar Dr.		10f. Zip Code Ellicott City		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry C & P Telephone Co.			
	17. Father's Name (First, Middle, Last) Herman Henry Roemer				18. Mother's Name (First, Middle, Maiden Surname) Eve Seek			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Katherine Roemer / spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 Rosemar Dr. Ellicott City, MD. 21043			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery		Date 8-23-2000		20c. Location - City or Town, State Elkridge, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ed's Stage Lung Disease Due to (or as a consequence of): b. recurrent aspiration pneumonia Due to (or as a consequence of): c. Asthma - Long Standing Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ys uks ys							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number D-34868		29d. Date signed (Month, Day, Year) August 21, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPICER HOST Lorie Patient, PC Columbia, MD 21044							
State Registrar	31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26375

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Tireice Robinson		2. Date of Death Month Day Year August 7, 2000		3. Time of Death 9:13 Am
	4a. Facility Name (If not Institution, give street and number) University of Maryland Medical System		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore
Funeral Director	5. Social Security Number Unknown	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) 10-17-93		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 2623 Park Heights Terrance			10f. Zip Code 21215		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1st. Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Child		16b. Kind of Business/Industry Child	
17. Father's Name (First, Middle, Last) Lawrence Jackson		18. Mother's Name (First, Middle, Maiden Summa) Cindy Hitchcock			
19a. Informant's Name/Relationship (Type, Print) Patricia Jackson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 McCulloh Street Baltimore, Maryland 21217			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Pk. Cem.		20c. Location - City or Town, State 08-10-2000 Randallstown, MD	
21. Signature of Funeral Service Licensee Bernadine Johnson		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Carbon monoxide poisoning Due to (or as a consequence of):</p> <p>b. Smoke inhalation Due to (or as a consequence of):</p> <p>c. Cardiopulmonary arrest Due to (or as a consequence of):</p> <p>d. _____</p>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<p>Cardiopulmonary arrest</p> <p>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 8/7/00		28b. Time of Injury 5:30 AM	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred House fire	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2623 Park Heights, Baltimore, MD	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number D0050845		29d. Date signed (Month, Day, Year) 8/7/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John P. Straumanis MD UMMS 22 S. Greene St Baltimore, MD					
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DONNIE M. RUSZKIEWICZ

State of Maryland / Department of Health and Mental Hygiene

PER MEO G786 8-31-00 WR.
Certificate of Death

00 26376

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Donald John Ruskiewicz			2. Date of Death Month Day Year AUGUST 18 2000		3. Time of Death 16:26
4a. Facility Name (If not institution, give street and number) 8823 PULASKI HIGHWAY			4b. City, Town, or Location of Death ESSEX		4c. County of Death BALTIMORE
5. Social Security Number 220-62-2309	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 14, 1955
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 12 Woody Road			10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) 9			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) Marion J. Ruskiewicz			18. Mother's Name (First, Middle, Maiden Surname) Mary D. Dominicus		
19a. Informant's Name/Relationship (Type, Print) Marion J. Ruskiewicz (father)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Woody Road, Baltimore, Maryland 21221		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Location - City or Town, State 8/21/2000 Baltimore, Maryland	
21. Signature of Funeral Service Licensee			22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221		

To Be Completed by Funeral Director

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		HEAD INJURIES a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year) 8-18-00		28b. Time of Injury at Work? 4:00 P APPROX M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred SUBJECT STRUCK BY TRAIN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) REAR OF STORE		
28f. Location (Street and Number or Rural Route Number, City or Town, State) 8823 PULASKI HIGHWAY, ESSEX, BALTO.CO.		28g. Location (Street and Number or Rural Route Number, City or Town, State) MD.		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Stephen S. Radwicz, M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 19, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radwicz, 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature B. Sparks		

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26377

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CYNTHIA RAY		2. Date of Death Month Day Year AUGUST 15 2000		3. Time of Death 0250
	4a. Facility Name (If not institution, give street and number) SR FALLSTON GEN HOSPITAL		4b. City, Town, or Location of Death FALLSTON		4c. County of Death HARFORD
Funeral Director	5. Social Security Number 217-64-0707	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 6/11/56		9. Birthplace (State or Foreign Country) Balto., MD		
Usual Residence of Decedent					
10a. State MD		10b. County Harford		10c. City, Town or Location Baldwin	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 13829 Manor Glen Rd.		10f. Zip Code 21013		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (14 or 5+) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Balto. County Board of Ed.	
17. Father's Name (First, Middle, Last) Henry Edward Ruppertsberger		18. Mother's Name (First, Middle, Maiden Summa) Marguerite Catherine Albers			
19a. Informant's Name/Relationship (Type, Print) Mr. Jonathan Ray (husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13829 Manor Glen Rd. Baldwin, MD 21013			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Lutheran Ch Cemetery		20c. Location - City or Town, State 8/18/00 Sweet Air, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility E.F. Lassahn Funeral Home 11750 Belair Rd., Kingsville, MD 21087			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. METASTATIC CANCER Due to (or as a consequence of):					
b. CANCER BREAST Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  OME		29c. License number OCME		29d. Date signed (Month, Day, Year) AUG 15, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G S PRABHU MD 728 BELAIR RD BALTIMORE MD 21014					
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 			

00-4564-027

ADE W. RUFFIN

JVW

AMEND ITEM: #18 PER F.H. G786 8-19-00 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26378

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ADEWOLE RUFFIN		2. Date of Death Month AUGUST Day 15 , Year 2000		3. Time of Death 02:25 A.M.	
4a. Facility Name (If not institution, give street and number) LITTLE PATUXENT PKWY @ GOVERNOR WARFIELD			4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD
5. Social Security Number 142-88-1390	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 19 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) 04-16-81	9. Birthplace (State or Foreign Country) PA
Usual Residence of Decedent					
10a. State MD		10b. County HOWARD		10c. City, Town or Location COLUMBIA	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 5696 THICKET LANE			10f. Zip Code 21044		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (13-16) N/A			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry SCHOOL			
17. Father's Name (First, Middle, Last) ALTON RUFFIN			18. Mother's Name (First, Middle, Maiden Surname) BOBI DUNLAP BOBI DUNLAP		
19a. Informant's Name/Relationship (Type, Print) BOBI RUFFIN (MOTHER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5696 THICKET LN., COLUMBIA, MD. 21044		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE CEME.		20c. Location - City or Town, State 8-19-00 ELKRIDGE, MD	
21. Signature of Funeral Service Licensee <i>Yaughn C. Greene</i>			22. Name and Address of Facility YAUGHN C. GREENE FUNERAL SERVICE 5151 BAUTO. NATL PIKE, BAUTO. MD. 21229		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/15/00		28b. Time of Injury 02:55 AM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject driver involved in accident			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway		28f. Location (Street and Number or Rural/Route Number, City or Town, State) Little Patuxent Parkway at Governor Warfield Howard County Maryland			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Theodore M. Kergus</i>			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 15, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. Kergus 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 19 2000		32. Registrar's Signature <i>Benjamin B. Sparks</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26379

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LONNIE REAVES		2. Date of Death Month Day Year AUGUST 11 2000		3. Time of Death 10:18A
	4a. Facility Name (If not institution, give street and number) BON SECOUR Hospital		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 251 84 6212	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) MAR 10 1947		9. Birthplace (State or Foreign Country) S. Carolina		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1610 W. Lexington Street AD		10f. Zip Code 21223		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook		16b. Kind of Business/Industry Maryland School for the Blind		
	17. Father's Name (First, Middle, Last) DAVID REAVES		18. Mother's Name (First, Middle, Maiden Surname) Estella Smith		
	19a. Informant's Name/Relationship (Type, Print) Lionel D. Reaves / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Dupont Ave BALTIMORE, MD 21215		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		20c. Location - City or Town, State Arbutus, Maryland
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. POST-OBSTRUCTIVE PNEUMONIA					7 DAYS
Due to (or as a consequence of): b. PROBABLE CENTRAL HILAR MASS					UNKNOWN
Due to (or as a consequence of): c.					
Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE LIVER DISEASE ANEMIA					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature] MD.		29c. License number D 23300		29d. Date signed (Month, Day, Year) AUGUST 11 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR D. PATEL 2000 W. BALTO. ST. BALTO MD. 21223					
31. Date filed (Month, Day, Year) AUG 19 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26380

Amended Item#28a per PHYG786 8/21/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Margaret Sullivan				2. Date of Death Month August Day 14 , Year 2000				3. Time of Death 4:29 P.M.	
	4a. Facility Name (If not institution, give street and number) 10523 Wil-Mar Place				4b. City, Town, or Location of Death Cockeysville				4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 020-03-0849		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) March 28, 1916		9. Birthplace (State or Foreign Country) Meriden, CT.	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Cockeysville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 105 23 Wil-Mar Place				10f. Zip Code 21030		10g. Citizen of What Country? United States of America				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 02				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk				16b. Kind of Business/Industry Federal Govt.		
17. Father's Name (First, Middle, Last) Howard Joseph Pearsall				18. Mother's Name (First, Middle, Maiden Surname) Maude Eunice Hinton						
19a. Informant's Name/Relationship (Type, Print) Mr. Laurence Howard Sullivan(Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10523 Wil-Mar Place Cockeysville, Maryland 21030						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 8/17/2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 min.		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8-14-2000		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier FRANCESCO GRASSO MD				29c. License number D-38363		29d. Date signed (Month, Day, Year) 8-15-00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FRANCESCO GRASSO MD 6569 N. CHARLES ST TOWSON										
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26381

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Oliver Albert Smith, Jr.				2. Date of Death Month Day Year August 19, 2000		3. Time of Death 4:26 a.m.	
	4a. Facility Name (If not institution, give street and number) Riverview Nursing Center				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-24-1023	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 22, 1930		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1415 Strawflower, Apartment B				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-1952		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Packer		16b. Kind of Business/Industry Meat Company		
17. Father's Name (First, Middle, Last) Oliver A. Smith, SR.				18. Mother's Name (First, Middle, Maiden Surname) Gladys Gertrude Hughes				
19a. Informant's Name/Relationship (Type, Print) Ruth Elnora Smith (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Strawflower, Apt. B, Baltimore, Maryland 21221				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory		Date 8/21/2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Executive 				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>End Stage Dementia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D43725		29d. Date signed (Month, Day, Year) 8/21/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAITMOOD 201-109 Back River Neck Rd Baltimore MD 21221								
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 00028.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 30 per dvr G786 8/21/00 State of Maryland / Department of Health and Mental Hygiene

00 26382

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Sommers Seidler				2. Date of Death Month Day Year 08 16 2000				3. Time of Death 2:25 PM	
	4a. Facility Name (If not institution, give street and number) Broadmead				4b. City, Town, or Location of Death Cockeysville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-10-7325		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Aug. 28, 1912		9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Cockeysville	
Usual Residence of Decedent										
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
10e. Street and Number 13801 York Road										
10f. Zip Code 21030										
10g. Citizen of What Country? U.S.A.										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker										
16b. Kind of Business/Industry Own Home										
17. Father's Name (First, Middle, Last) Norman L. Niedentohl										
18. Mother's Name (First, Middle, Maiden Surname) Helen Virginia Waidner										
19a. Informant's Name/Relationship (Type, Print) Mrs. Helen Seidler/Daughter										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6108 Maiden Lane Bethesda, Maryland 20817										
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.										
20c. Location - City or Town, State Towson, Maryland										
20d. Date 8/18/00										
21. Signature of Funeral Service Licensee Michael P. Seidler										
22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204										
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death 3HR										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD OLD AGE										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier J. Hanzar										
29c. License number D22627										
29d. Date signed (Month, Day, Year) 8/16/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadmead Nursing Home 13801 York Road Cockeysville, Maryland 21030										
31. Date filed (Month, Day, Year) AUG 21 2000										
32. Registrar's Signature Benjamin Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO 8-30-00 WR.

Reg. No.

00 26383

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Steven Svehla				2. Date of Death Month Day Year AUGUST 18, 2000				3. Time of Death 01:25 A.M.		
	4a. Facility Name (If not institution, give street and number) N/B JONES FALLS EXPRESSWAY PRIOR TO 695				4b. City, Town, or Location of Death RUXTON				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-02-5280		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 31 Yrs.		8. Date of Birth (Month, Day, Year) March 13 1969		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Cockeysville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 10606 Partridge Ln. #A2				10f. Zip Code 21030		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Manager				16b. Kind of Business/Industry Liquor Distributor		
	17. Father's Name (First, Middle, Last) John James Svehla				18. Mother's Name (First, Middle, Maiden Surname) Susan Walton						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. John J. Svehla/ Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3546 Anderson Ln. Jarrettsville, Md. 21084						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery		Date 8-22-00		20c. Location - City or Town, State Overlea, Md.		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SUBARACHNOID HEMORRHAGE Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) AUGUST 18, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Lock, MD 111 Penn Street, Baltimore, Maryland 21201											
State Registrar		31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26384

Amended Item# 8 per DVRG787 9/1/2000 EW

Amended item# 23a per FD C786 8-21-00 WJJ

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDIE SANDLER		2. Date of Death Month August Day 12 , Year 2000		3. Time of Death 9:42 am
	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 214-03-6378	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth FEB 21- 1912		9. Birthplace (State or Foreign) NEW YORK		
Usual Residence of Decedent					
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 6605 LINCO AVENUE			10f. Zip Code 21209		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) BERNARD RABINOWITZ			18. Mother's Name (First, Middle, Maiden Surname) CELIA BARAD		
19a. Informant's Name/Relationship (Type, Print) BERNARDINE GORDON/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 WILLOW GLEN DRIVE, BALTIMORE, MD. 21209		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FRIEDEL MARYLAND LODGE		20c. Location - City or Town, State 8/13/00 ROSEDALE, MD.	
21. Signature of Funeral Service licensee 		22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Respiratory failure Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Aspiration Pneumonia Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D-26748		29d. Date signed (Month, Day, Year) 8/13/2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR LUBEROI G. GOME. 6701 N. Charles St BALTO 21204					
31. Date filed (Month, Day, Year) AUG 21 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26385

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ben Tramble				2. Date of Death Month Day Year AUGUST 09, 2000				3. Time of Death 10:18PM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown				4c. County of Death	
Funeral Director	5. Social Security Number 271-12-6568		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Aug. 9, 1922		9. Birthplace (State or Foreign Country) Cincinnati, OH		Usual Residence of Decedent		10a. State D.C.		10b. County	
To Be Completed by Funeral Director	10c. City, Town or Location Washington				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 3700 North Capitol Street, N.W.	
	10f. Zip Code 20317				10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professional Navyman				16b. Kind of Business/Industry U.S. Navy	
	17. Father's Name (First, Middle, Last) James Tramble				18. Mother's Name (First, Middle, Maiden Surname) Rosetta Crum				19e. Informant's Name/Relationship (Type, Print) Matthew A. Hinton - Mortuary Off.	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 N. Capitol St., NW, Wash., DC 20317				20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery	
	20c. Location - City or Town, State Arlington, VA				21. Signature of Funeral Service Licensee John W. Leary CC0348				22. Name and Address of Facility Latney's Funeral Home, Inc., 3831 Georgia Ave., NW, Wash., DC 20011	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory Arrest Due to (or as a consequence of): Chronic Lung Disease Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alzheimer's Disease				Approximate Interval Between Onset and Death Seconds YES				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year) —	
28b. Time of injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier William Boyd II				29c. License number D14285				29d. Date signed (Month, Day, Year) 8-10-00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. WILLIAM BOYD II LEONARDTOWN, MD 20650				31. Date filed (Month, Day, Year) AUG 18 2000				32. Registrar's Signature James B. Sparks		

Handwritten text, possibly a signature or name, located in the middle section of the page.

Handwritten text, possibly a date or a short phrase, located in the lower middle section of the page.

Handwritten text, possibly a signature or name, located in the bottom right section of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26386

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE STOUT WALTON

2. Date of Death

Month Day Year
AUGUST 18 2000

3. Time of Death

12:35 P.M.

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

200-10-7713

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02/02/1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

100 Idlewild St. Apt 1B

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George I. Stout

18. Mother's Name (First, Middle, Maiden Surname)

Florence E. Garber

19a. Informant's Name/Relationship (Type, Print)

Deborah Harrison Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 E. Ring Factory Rd. Bel Air, MD 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

8/21

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Road Dundalk, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. end stage dementia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David S. Dunn

29c. License number

D32299

29d. Date signed (Month, Day, Year)

August 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID S. DUNN 615 W. Macphail

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

Bellevue B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26387

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll J. Woodruff						2. Date of Death Month Day Year August 20, 2000		3. Time of Death 12:30 A.M.		
	4a. Facility Name (If not institution, give street and number) 7539 Westfield Road						4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 246-38-8647		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Aug 11, 1930		9. Birthplace (State or Foreign Country) NC		
	Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 7539 Westfield Road						10f. Zip Code 21222		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-52		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dock Worker			16b. Kind of Business/Industry Freight				
17. Father's Name (First, Middle, Last) Lee Woodruff						18. Mother's Name (First, Middle, Maiden Surname) Hattie Brown					
19a. Informant's Name/Relationship (Type, Print) Shirley Woodruff/Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7539 Westfield Road, Baltimore, MD 21222					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		Date 8-22-00		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore, MD 21237							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Congestive Heart Failure</u> Due to (or as a consequence of): b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <div style="position: absolute; left: 300px; top: 550px; font-size: 40px;">}</div>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D26835		29d. Date signed (Month, Day, Year) 8/21/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Valle 1576 Merritt Blvd 21222											
31. Date filed (Month, Day, Year) AUG 21 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26388

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gerald Alwyn Wade		2. Date of Death Month AUGUST Day 19 Year 2000		3. Time of Death 9:30 AM
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 369-30-6453	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 12, 1931		9. Birthplace (State or Foreign Country) Michigan		
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 202 Long Cove Lane		10f. Zip Code 21221	
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-1954	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Agent		16b. Kind of Business/Industry Steam Ship Line		17. Father's Name (First, Middle, Last) Joseph Wade	
18. Mother's Name (First, Middle, Maiden Surname) Gladys Unk.		19a. Informant's Name/Relationship (Type, Print) Gloria E. Wade (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Long Cove Lane, Baltimore, Maryland 21221	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Brudzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>ISCHEMIC CARDIOMYOPATHY</p> <p>Due to (or as a consequence of):</p> <p>CORONARY ARTERY DISEASE</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
PERIPHERAL VASCULAR DISEASE					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 					
29c. License number D 37254					
29d. Date signed (Month, Day, Year) 8/19/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204					
31. Date filed (Month, Day, Year) AUG 21 2000					
32. Registrar's Signature 					

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26389

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Milton H. Wills, Sr.

2. Date of Death

Month
AugustDay
17Year
2000

3. Time of Death

07:10 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-46-4707

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 4, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

412 Montemar Ave.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Fireman

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Milton W. Wills

18. Mother's Name (First, Middle, Maiden Surname)

Anna Schmidt

19a. Informant's Name/Relationship (Type, Print)

Milton H. Wills, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Montemar Ave. Catonsville, MD. 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Jerusalem Lutheran
Church Cemetery

Date

8-21-00

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

▶ *[Signature]*

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus, MD. 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Pulmonary edema or embolism
Due to (or as a consequence of):

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. sepsis
Due to (or as a consequence of):
c. renal failure
Due to (or as a consequence of):

days

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Hwan-Y. Yoo, M.D.*

29c. License number

D0053514

29d. Date signed (Month, Day, Year)

August 17 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hwan-Y. Yoo, M.D., St. Agnes Hospital

31. Date filed (Month, Day, Year)

AUG 21 2000

32. Registrar's Signature

▶ *[Signature]*State
Registrar

ORIGINAL

Milton Wills, Sr.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A-11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26390

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Dorothy M. Wittig</u>				2. Date of Death Month <u>Aug</u> Day <u>18</u> Year <u>2000</u>		3. Time of Death <u>1:45 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Univ of MD Medical Center</u>				4b. City, Town, or Location of Death <u>BALTO.</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>217-22-2464</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>78</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>OCT 9, 1921</u>	
	10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTIMORE</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>136 N. BRADFORD ST.</u>				10f. Zip Code <u>21224</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u>N/A</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Home</u>		
17. Father's Name (First, Middle, Last) <u>GEORGE WITTIG</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>LILLY GROVES</u>				
19a. Informant's Name/Relationship (Type, Print) <u>MARGARET PECORA</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2335 E. FAYETTE ST. BALTO MD 21224</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>OAKLAWN Cemetery</u>		20c. Location - City or Town, State <u>BALTO. MD.</u>		
21. Signature of Funeral Service Licensee <u>Hartley Miller</u>				22. Name and Address of Facility <u>HARTLEY MILLER Funeral Home CHD. 7527 HARFORD RD. BALTO. MD 21234</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>BOWEL Ischemia</u> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier <u>[Signature]</u>
29c. License number <u>P11446</u>				29d. Date signed (Month, Day, Year) <u>8/18/00</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Amer Quaddora 4809 Lyon Road DR #C Owings Mills MD 21117</u>								
31. Date filed (Month, Day, Year) <u>AUG 19 2000</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26391

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES S. WOODLAND

2. Date of Death

August 18, 2000

3. Time of Death

1035AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

220 20 5832

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 14, 1927

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
Maryland

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

1200 DRUID HILL AVE

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 YEAR

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

WILLIAM JACKSON

18. Mother's Name (First, Middle, Maiden Surname)

QUMI CAUL

19a. Informant's Name/Relationship (Type, Print)

Katrice Woodland Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2315 W. Baltimore Street Baltimore, Md 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans Cemetery

Date

8-22-2000

20c. Location - City or Town, State

Bowie Mills, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATHAM - HARRIS Funeral Home

5240 REISTERSTOWN ROAD

Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D292071

29d. Date signed (Month, Day, Year)

8/18/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland General Hosp. Balt. Md.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 19 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #10A,10C PER F.H. G789 State of Maryland / Department of Health and Mental Hygiene
Amend #18.Per F.H. PGC 8-4-2000 cr

Certificate of Death

Reg. No. 00 26392

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Robert Aiken</u>				2. Date of Death Month <u>8</u> Day <u>2</u> Year <u>2000</u>		3. Time of Death <u>2:00 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Hebrew Home of Greater Washington</u>				4b. City, Town, or Location of Death <u>Rockville, Md</u>		4c. County of Death <u>Montgomery</u>	
Funeral Director	5. Social Security Number <u>249 44 1408</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>68</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <u>January 17, 1932</u>	9. Birthplace (State or Foreign Country) <u>S. Carolina</u>
	Usual Residence of Decedent							
10a. State <u>D.C.</u>		10b. County		10c. City, Town or Location <u>WASHINGTON</u> <u>Washington D.C.</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number <u>3016 Nelson Place S.E. #2</u>				10f. Zip Code <u>20019</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (14 or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Truck Driver</u>		16b. Kind of Business/Industry <u>Govt/Private</u>		
17. Father's Name (First, Middle, Last) <u>Henry Aiken</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Willie Mae Hadgood Hagood</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Margaret Aiken/wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3016 Nelson Place SE #2 Washington DC 20019</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Maryland National Cem</u>		Date <u>8-8-00</u>		20c. Location - City or Town, State <u>Laurel, Maryland</u>		
21. Signature of Funeral Service Licensee <u>Samuel B. Burrell</u>				22. Name and Address of Facility <u>MARSHALL'S FUNERAL HOME OF MD</u> <u>4308 Suitland Road Suitland, MD 20746</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>urinary infection</u> Due to (or as a consequence of): b. <u>decubitus ulcer</u> Due to (or as a consequence of): c. <u>stage 3 lung cancer</u> Due to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Scott M. Joshi</u>		29c. License number <u>MD 00052837</u>		29d. Date signed (Month, Day, Year) <u>8/2/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Scott M Joshi, Washington Hosp (tr, Rm 6B10, 110 Irving St, NW Washington, DC</u>								
31. Date filed (Month, Day, Year) <u>AUG 04 2000</u>		32. Registrar's Signature <u>John S. Sparks</u>						

50230 011

B.K.S

WILLIAM ALLEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26393

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Michael Alley		2. Date of Death Month Day Year AUG. 4, 2000		3. Time of Death 1424 PM														
	4a. Facility Name (If not institution, give street and number) 522 MAUDE AVENUE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death														
Funeral Director	5. Social Security Number 218-15-2955	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 23 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.														
	8. Date of Birth (Month, Day, Year) Nov. 8, 1976		9. Birthplace (State or Foreign Country) MD																
Usual Residence of Decedent																			
10a. State MD		10b. County		10c. City, Town or Location Baltimore															
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																			
10e. Street and Number 522 Maude Avenue			10f. Zip Code 21225		10g. Citizen of What Country? USA														
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:															
14. Race - American Indian, Black, White, etc. Specify: white																			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Carpentry														
17. Father's Name (First, Middle, Last) Michael Alley			18. Mother's Name (First, Middle, Maiden Surname) Karen Miller																
19a. Informant's Name/Relationship (Type, Print) Karen Alley/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 A Street, Lothian, MD 20711																
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem.		20c. Location - City or Town, State 8/6/00 Alex., VA															
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Hanging</td> <td>Due to (or as a consequence of):</td> <td rowspan="4"></td> </tr> <tr> <td>b.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Hanging	Due to (or as a consequence of):		b.		Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Hanging	Due to (or as a consequence of):																
	b.		Due to (or as a consequence of):																
	c.		Due to (or as a consequence of):																
	d.		Due to (or as a consequence of):																
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE																			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/4/00 (Found)		28b. Time of Injury 1400 M															
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject hanged Self																	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House		28f. Location (Street and Number or Rural Route Number, City or Town, State) 522 Maude Avenue Baltimore, Maryland																	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 5, 2000															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201																			
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26394

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAUL DARREN BOONE				2. Date of Death Month Day Year August 05 2000		3. Time of Death 08:24 P.M.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 218-04-0438		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 29 Yrs.		8. Date of Birth (Month, Day, Year) June 21, 1971		
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Brunswick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Concrete Finisher				16b. Kind of Business/Industry Bar-Nel Concrete Co.	
17. Father's Name (First, Middle, Last) Larry Wayne Boone				18. Mother's Name (First, Middle, Maiden Surname) Arlyn Jean Zentz					
19a. Informant's Name/Relationship (Type, Print) Terri R. Boone (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Maple Terrace Ln. Apt. 105, Brunswick, MD 21716					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens		20c. Location - City or Town, State Frederick, Maryland		20d. Date 8/10/00	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788					
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head & Neck Injury Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 8/5/00		28b. Time of Injury 1921 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred subject driven off all known roads struck thru				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway				28f. Location (Street and Number or Rural Route Number, City or Town, State) about 1/2 mile from road, Brunswick	
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) August 7, 2000	
29b. Signature and title of certifier <i>[Signature]</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 08 2000				32. Registrar Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26395

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN WALTER BRUNING				2. Date of Death Month Day Year AUGUST 3, 2000		3. Time of Death 3:55 AM
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
Funeral Director	5. Social Security Number 040-26-4067	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 9 1933	9. Birthplace (State or Foreign Country) Connecticut
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Frederick	10c. City, Town or Location Knoxville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 628 Tritapoe Drive			10f. Zip Code 21758		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker		16b. Kind of Business/Industry Jefferson Pastry Shop Jefferson, MD		
	17. Father's Name (First, Middle, Last) Walter Sebastian Bruning			18. Mother's Name (First, Middle, Maiden Surname) Katherine Veronica Sugure			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Patricia S. Bruning, Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Tritapoe Drive, Knoxville, MD 21758			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		Date 8/7/2000	20c. Location - City or Town, State Petersville, MD	
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner		22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE INTESTINAL ISCHEMIA Due to (or as a consequence of): b. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
State Registrar	29b. Signature and title of certifier Paul McNeel MD		29c. License number D0045892		29d. Date signed (Month, Day, Year) 8/3/2000		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PAUL MCNEEL MD 581 W 7th ST FREDERICK, MD 21701						
	31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature B. Apant				

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26396

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Caroline Beachley				2. Date of Death Month August Day 1 Year 2000				3. Time of Death 10:47 PM	
	4a. Facility Name (If not Institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-38-7623		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		8. Date of Birth Month Jan. Day 7 Year 1900		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10e. Street and Number 409 Magnolia Avenue				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business/Industry Board of Education				
	17. Father's Name (First, Middle, Last) Albert Carlton Beachley				18. Mother's Name (First, Middle, Maiden Surname) Catherine Caroline Bowlus					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Miss Pamela F. Beachley, Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 469 Carrollton Drive, Frederick, Md. 21701					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Reformed Cemetery, Aug. 4, 2000		Data Middletown, Md.		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee Richard E. Gray M00255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Atherosclerotic Cardiovascular disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Multiple strokes				Approximate Interval Between Onset and Death 6 months 20 years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple strokes							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Ali J. Harkat				29c. License number D35783		29d. Date signed (Month, Day, Year) August 2, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali J. Harkat 300 W 9th St. Frederick, MD										
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature [Signature]								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26397

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hettie Bell				2. Date of Death Month August Day 2 , Year 2000		3. Time of Death 2010									
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's									
Funeral Director	5. Social Security Number 217-46-4488	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 24, 1945		9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Shady Side		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number 1310 Juniper St.				10f. Zip Code 20764		10g. Citizen of What Country? USA									
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Cafeteria											
	17. Father's Name (First, Middle, Last) Calvert W. Burley				18. Mother's Name (First, Middle, Maiden Surname) Josephine Ennis											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Yolanda Bell/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Juniper St. Shady Side, MD 20764											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem. Gardens		Date 8/11/00		20c. Location - City or Town, State Davidsonville, MD									
	21. Signature of Funeral Service Licensee Blades G. Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Massive Ischemic stroke on Right Hemisphere Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death days</td> </tr> <tr> <td>b. MRSA Sepsis Due to (or as a consequence of):</td> <td>days</td> </tr> <tr> <td>c. Diabetes Mellitus Type II Due to (or as a consequence of):</td> <td>Years</td> </tr> <tr> <td>d. End stage Renal disease Due to (or as a consequence of):</td> <td>Years</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Massive Ischemic stroke on Right Hemisphere Due to (or as a consequence of):	Approximate Interval Between Onset and Death days	b. MRSA Sepsis Due to (or as a consequence of):	days	c. Diabetes Mellitus Type II Due to (or as a consequence of):	Years	d. End stage Renal disease Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Massive Ischemic stroke on Right Hemisphere Due to (or as a consequence of):	Approximate Interval Between Onset and Death days														
	b. MRSA Sepsis Due to (or as a consequence of):	days														
	c. Diabetes Mellitus Type II Due to (or as a consequence of):	Years														
	d. End stage Renal disease Due to (or as a consequence of):	Years														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic cardiomyopathy, meningitis MRSA septicemia massive left hemiparesis due to ischemic stroke						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Peter W. [Signature]		29c. License number 00012884		29d. Date signed (Month, Day, Year) 8-3-00								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER W. TIM M.D. 7900 Old Branch Ave Suite 101. Clinton Maryland 20735																
31. Date filed (Month, Day, Year) AUG 07 2000				32. Registrar's Signature [Signature]												

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

8

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the results, and the conclusions drawn from the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the study, and the suggestions for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and the conclusions drawn from the study.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.

8. The eighth part of the report is a conclusion. It includes a final statement of the findings and the conclusions drawn from the study.

9. The ninth part of the report is a list of the authors and their affiliations. It includes a list of the names of the authors and the institutions they are associated with.

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State of Maryland / Department of Health and Mental Hygiene

00 26398

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA BROOME		2. Date of Death Month AUGUST Day 1 Year 2000		3. Time of Death 04:01 am
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert
Funeral Director	5. Social Security Number 212-24-4428	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct. 14, 1926		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location Owings
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 2322 Fifth Street		10f. Zip Code 20736		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Church
	17. Father's Name (First, Middle, Last) Thomas Chase		18. Mother's Name (First, Middle, Maiden Surname) Aleatha Thomas		
	19a. Informant's Name/Relationship (Type, Print) Joyce Estep/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2322 Fifth St. Owings, MD 20736		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ernestine Jones Cemetery		20c. Location - City or Town, State Chesapeake Beach, MD
	21. Signature of Funeral Service Licensee ▶ [Signature] G. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Bronchogenic Cancer				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> 1 <input type="checkbox"/> Yes <input type="checkbox"/> No
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and Title of Certifier ▶ [Signature]		29c. License number 051949		29d. Date signed (Month, Day, Year) 8/1/00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID GALLATIN, M.D. PRINCE FREDERICK, MD 20678				
	31. Date filed (Month, Day, Year) AUG 03 2000		32. Registrar's Signature ▶ [Signature]		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 26399

Amended item #17 08/07/2000 FCHD KS Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph David Cubitt

2. Date of Death

August 3, 2000

3. Time of Death

6:19 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

220-05-8092

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 16, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22 Frederick Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lineman

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

Millard James O. Cubitt

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Fawley

19a. Informant's Name/Relationship (Type, Print)

Mrs. Helen G. Cubitt, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Frederick Avenue, Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery, Aug. 5, 2000

Date

20c. Location - City or Town, State

Frederick, Md.

21. Signature of Funeral Service Licensee

Richard C. C. Basford 00021

22. Name and Address of Facility

Keeney and Basford PA Funeral Home
106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

1 year

Due to (or as a consequence of):

Ventricular Hypertrophy

years

Due to (or as a consequence of):

Aortic Stenosis

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer Stage 2B

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 32245

29d. Date signed (Month, Day, Year)

August 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy Jones, M.D., 56 Thomas Johnson Drive, Frederick, Maryland 21702

State
Registrar

31. Date filed (Month, Day, Year)

AUG 04 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26400

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Fleming Christensen, Sr.

2. Date of Death

Month Day Year
8 3 2000

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

3 East 15th Street

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

573-24-1498

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec 29, 1926

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3 East 15th Street

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No 1954
If Yes, Give Year or Dates: -1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
12 -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

career military

16b. Kind of Business/Industry

US ARMY

17. Father's Name (First, Middle, Last)

Charles Christensen

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Fleming

19a. Informant's Name/Relationship (Type, Print)

Okhi Christensen / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 East 15th Street, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

8/8/00

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myelogenous leukemia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 m

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 48184

29d. Date signed (Month, Day, Year)

Aug 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elhamy Eskander MD 501 W 7th street Frederick MD 21701

State
Registrar

31. Date filed (Month, Day, Year)

AUG 7 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

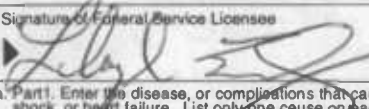
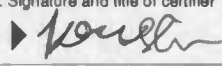

State of Maryland / Department of Health and Mental Hygiene

amend item 26 per phys. G786 8/24/00 yf

Certificate of Death

Reg. No.

00 26401

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ethel Chapman				2. Date of Death Month Day Year August 6 2000				3. Time of Death 05:30AM		
	4a. Facility Name (If not institution, give street and number) 14650 Poplar Hill Road				4b. City, Town, or Location of Death Waldorf				4c. County of Death Charles		
Funeral Director	5. Social Security Number 579-24-2325		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F XXX		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) January 16, 1916		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland 10b. County Charles 10c. City, Town or Location Waldorf 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 14650 Poplar Hill Rd				10f. Zip Code 20601		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Self-Employed					
17. Father's Name (First, Middle, Last) John Chapman					18. Mother's Name (First, Middle, Maiden Surname) Irma Yates						
19a. Informant's Name/Relationship (Type, Print) Delores Brooks / Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14650 Poplar Hill Rd Waldorf Maryland 20601						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cem. August 12, 2000			20c. Location - City or Town, State Waldorf MD					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility M191 Adams Funeral Home P.A. Aquasco MD 20608						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Leukemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> XXX <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier  M. Mathur					29c. License number D28352		29d. Date signed (Month, Day, Year) August 7, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646											
31. Date filed (Month, Day, Year) AUG 08 2000					32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 26402**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Lewis Danner		2. Date of Death Month Aug. Day 2, Year 2000		3. Time of Death 8:20 PM
	4e. Facility Name (If not institution, give street and number) 201 Catoctin Ave.		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
Funeral Director	5. Social Security Number 220-05-7975	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year Aug. 29, 1920		9. Birthplace (State or Foreign Country) MD.		
Usual Residence of Decedent					
10a. State MD.		10b. County Frederick		10c. City, Town or Location Frederick	
10e. Street and Number 201 Catoctin Ave.		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No W. W. If Yes, Give Year or Dates: II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic	
16b. Kind of Business/Industry railroad		17. Father's Name (First, Middle, Last) Harvey L. Danner		18. Mother's Name (First, Middle, Maiden Surname) Lucy Nash	
19a. Informant's Name/Relationship (Type, Print) Mary I. Danner (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Catoctin Ave., Frederick, MD. 21701			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant View Cemetery		20c. Location - City or Town, State Burkittsville, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769			
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. congestive heart failure Due to (or as a consequence of):			Approximate Interval Between Onset and Death weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. valvular heart disease Due to (or as a consequence of):			years
c.		Due to (or as a consequence of):			
d.		Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease, dementia, Parkinson's disease					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier Kathleen W Stern MD		29c. License number D32073		29d. Date signed (Month, Day, Year) 8/8/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen W. Stern MD, 610 Ninth Ave, Brunswick, Md. 21716					
31. Date filed (Month, Day, Year) AUG 08 2000		32. Registrar's Signature 			

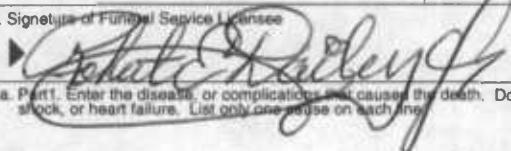
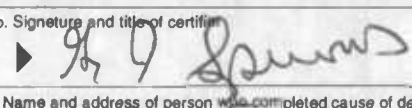

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26403

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA LOUISE ELIZABETH DAVIS				2. Date of Death Month Day Year August 7, 2000		3. Time of Death 1630	
	4a. Facility Name (If not institution, give street and number) Genesis Spa Creek Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 215-17-1077	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 10, 1920		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 35 Milkshake Lane				10f. Zip Code 21401		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) John A. Brashears				18. Mother's Name (First, Middle, Maiden Surname) Georgia Zula Lowe				
19a. Informant's Name/Relationship (Type, Print) Judith A. Weitzell (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Old County Road, Severna Park, MD 21146				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 8/10/00		20c. Location - City or Town, State Smithsburg, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Cardiomyopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3M								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 032036		29d. Date signed (Month, Day, Year) 8/8/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary J. Sprase 2108 P. Donah Drive Chester, MD 21619								
State Registrar		31. Date filed (Month, Day, Year) AUG 10 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26404

amend item 5,18, per fh G786 8/21/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EARIE HELENA DANIELS		2. Date of Death Month Day Year JUNE 21 2000		3. Time of Death 9:50 PM
	4a. Facility Name (If not Institution, give street and number) SHORE NURSING & REHABILITATION CTR.		4b. City, Town, or Location of Death DENTON		4c. County of Death CAROLINE
Funeral Director	5. Social Security Number 206-12-4073	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	8. Date of Birth Month Day Year 6-15-1913	
	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10a. State PA	10b. County Delaware	Chester		
	10e. Street and Number 737 Engle St.		10f. Zip Code 19013		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry OWN Home
	17. Father's Name (First, Middle, Last) Daniel Lake		18. Mother's Name (First, Middle, Maiden Surname) Daisy Wright-Lake		
	19a. Informant's Name/Relationship (Type, Print) Jackie Thomas		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9157 Tuckahoe Rd. Denton, MD 21629		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Grove		20c. Location - City or Town, State 6/26/00 Denton, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Harvey C. Smith, Jr. 1000 N DuPont Pkwy, New Castle, DE 19720		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Staph Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. { c. { d. {				Approximate Interval Between Onset and Death 6mo.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Rheumatoid arthritis				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and Title of certifier 		29c. License number D35284		29d. Date signed (Month, Day, Year) 6/22/00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREA ALLEN 219 S. Washington St Easton MD 21601				
31. Date filed (Month, Day, Year) JUN 26 2000		32. Registrar's Signature 			

ORIGINAL

0-1-1-1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26405

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lela Irene Fretz				2. Date of Death Month August Day 3 Year 2000		3. Time of Death 1:00 A.M.		
	4a. Facility Name (If not institution, give street and number) Mennonite Fellowship Home				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 220-46-8216		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 12, 1912		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12349 Huyett Lane		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Health Care		17. Father's Name (First, Middle, Last) George Eshleman		18. Mother's Name (First, Middle, Maiden Surname) Amanda Weaver	
19a. Informant's Name/Relationship (Type, Print) Lois Keener/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13859 Cearfoss Pike Hagerstown, Md. 21740		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Reiff Mennonite Church Cemetery		20c. Location - City or Town, State 8/7/00 Cearfoss, Md.	
21. Signature of Funeral Service Licensee H. Martin Zimmerman Jr.		22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. GASTRIC ULCER Due to (or as a consequence of): b. ARTHRITIS MEDICATIONS. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 wks			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NBP, OAD, ASD		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Wayne Murray M.D.		29c. License number D23815		29d. Date signed (Month, Day, Year) 8/3/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature Geneva Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

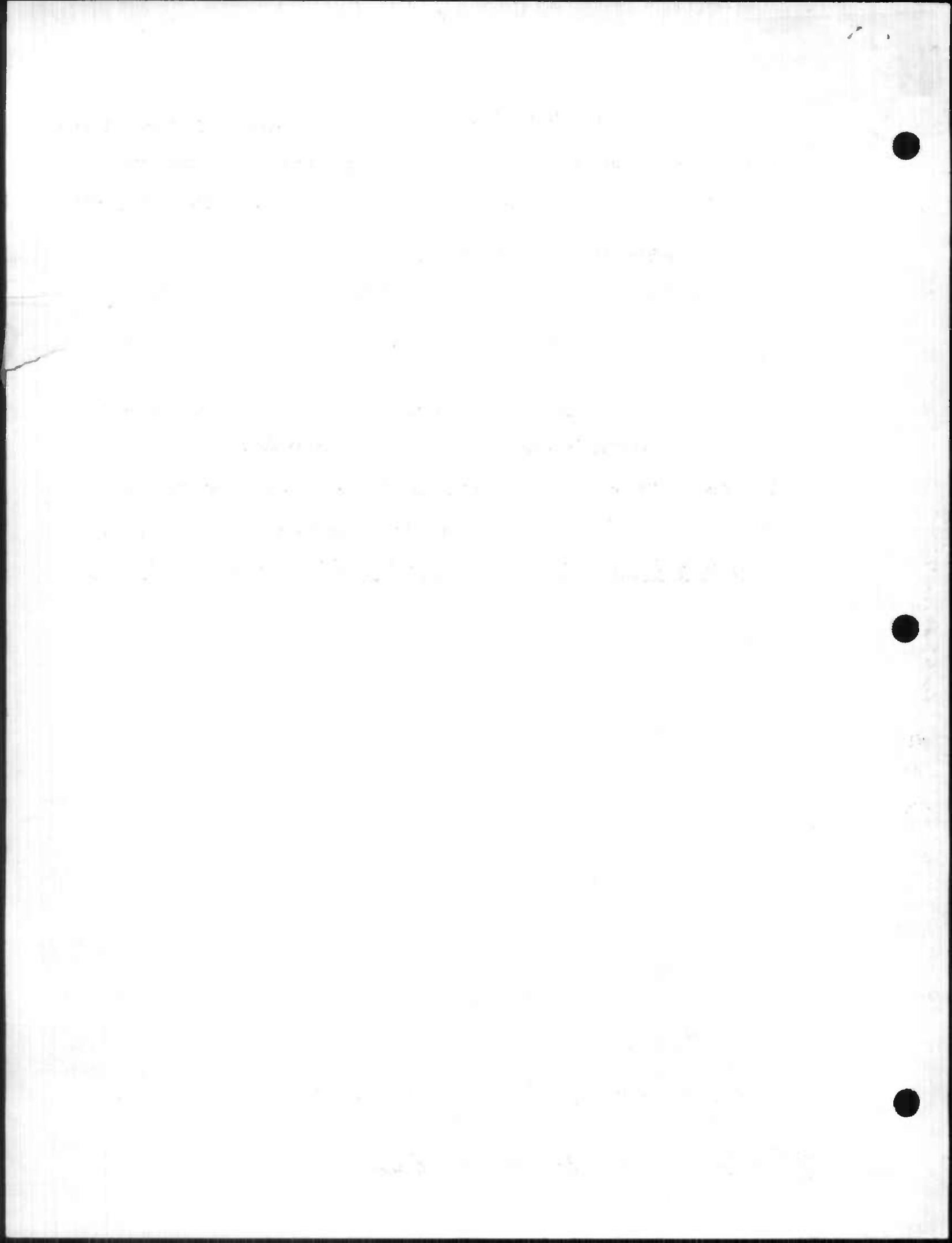
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



00-4506-510

James GUINN

JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A F PER MEO ^{G786-8-23-00 WR} Certificate of Death

Reg. No.

00 26406

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Alan GUINN

2. Date of Death

Month Day Year
AUGUST 12. 2000

3. Time of Death

03:09 A.M.

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217 70 8400

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Mar. 25, 1956

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

10c. City, Town or Location
Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5115 Benton Heights Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

self employed truck driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Cherry Clint Guinn

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Leona Hale

19a. Informant's Name/Relationship (Type, Print)

Larry D. Guinn (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2360 Cari Ct., Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Southern Memorial Gardens

Date

8-16-00

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

ACUTE NARCOTIC INTOXICATION

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☒ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

Month Day Year
Found: 8-12-00

28b. Time of Injury

UNKNOWN

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

FOUND AT HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 5115 BENTON HEIGHTS
AVE. BALTIMORE, MD29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. A. A.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26407

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mozella C. Greenwood		2. Date of Death Month Day Year August 1, 2000		3. Time of Death 1:50 P.M.
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing and Rehabilitation Ctr.		4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard
Funeral Director	5. Social Security Number 578-16-3255	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) March 8, 1926		9. Birthplace (State or Foreign Country) South Carolina		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Calvert	10c. City, Town or Location Dowell		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 13415 Dowell Road		10f. Zip Code 20629		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Ludie Woody		18. Mother's Name (First, Middle, Maiden Surname) Gertrude Beasley		
	19a. Informant's Name/Relationship (Type, Print) Drusilla Gough/Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 68 Dowell, MD 20629		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John UMC Cemetery		20c. Location - City or Town, State Lusby, MD
	21. Signature of Funeral Service Licensee Bledsoe A. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squamous cell carcinoma of esophagus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive cardiomyopathy				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and Title of Certifier Leonel Barahona		29c. License number D21928		29d. Date signed (Month, Day, Year) August 2nd/2000
State Registrar	30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Leonel Barahona, M.D. Baltimore, MD 21229				
	31. Date filed (Month, Day, Year) AUG 03 2000		32. Registrar's Signature B. Sparks		

THE STATE OF TEXAS,
COUNTY OF DALLAS.

I, the undersigned, Judge of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

Given under my hand and seal of office, at Dallas, Texas, this 1st day of January, 1901.

JOHN W. BROWN, Judge of the County of Dallas, Texas.

WITNESSES my hand and seal of office, at Dallas, Texas, this 1st day of January, 1901.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26408

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Millrose Hull				2. Date of Death Month Day Year August 5, 2000		3. Time of Death 6:31 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Health Care Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 156-22-0307	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 28, 1927		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1419 Hunting Horn Lane			10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry U. S. Government			
	17. Father's Name (First, Middle, Last) Edward William Dillon				18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Warren			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joanna Mae D'Antuono/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1419 Hunting Horn Lane, Frederick, Maryland 21703			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date Aug. 7, 2000		20c. Location - City or Town, State Smithsburg, Maryland	
	21. Signature of Funeral Service Licensee <i>Richard C.C. Basford</i> MO0021				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cirrhosis</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>William Johnson</i> MD				29c. License number D47556		29d. Date signed (Month, Day, Year) 8/7/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Johnson, M.D., 172 Thomas Johnson Drive, #202, Frederick, Md. 21702								
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature <i>B. Sparks</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26409

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Hamill				2. Date of Death Month Day Year August 1 2000		3. Time of Death 7:40 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-12-7445		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 27, 1926	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 5620-B Avonshire Place		10f. Zip Code 21703	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self				16b. Kind of Business/Industry homemaker		17. Father's Name (First, Middle, Last) Dennis Doyle	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Mary Carr				19a. Informant's Name/Relationship (Type, Print) John Hamill, husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620-B Avonshire Place, Frederick, MD 21703	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Crematory		20c. Location - City or Town, State 8/3/2000 Frederick, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Ryan M. Bueh				22. Name and Address of Facility Keeney and Basford Funeral Home		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. hypercalcemia Due to (or as a consequence of): c. ovarian mass Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier D. 48189	
To Be Completed by Physician/Medical Examiner	29c. License number D 48189				29d. Date signed (Month, Day, Year) 8/2/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 W 7th Street Frederick MD 21701	
	31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature B. [Signature]			

July 27
1904
Monday

Went to the
office and
worked on the
report.

July 28
Tuesday

Went to the
office and
worked on the
report.

X

202

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26410

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHAD				2. Date of Death Month August Day 10 Year 2000				3. Time of Death 12:16 PM	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL BALTIMORE CITY				4b. City, Town, or Location of Death				4c. County of Death	
Funeral Director	5. Social Security Number 159-68-6770		8. Sex 1 M 2 F		7. Age (In yrs. last birthday) 18 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) OCT 28, 1981		9. Birthplace (State or Foreign Country) YORK, PA.		10a. State PA		10b. County YORK		10c. City, Town or Location DALLASTOWN	
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 332 E. MAIN ST.		10f. Zip Code 17313		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry EDUCATION		17. Father's Name (First, Middle, Last) MICHAEL W. HOLPP		18. Mother's Name (First, Middle, Maiden Surname) GAIL A. McELREATH		19. Informant's Name/Relationship (Type, Print) MICHAEL W. HOLPP / FATHER		
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUSQUEHANNA VALLEY GARDENS		20c. Location - City or Town, State 8/14/00 YORK, PA		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility AUSTIN A. EBERLY FA 100 W. MAIN ST. DALLASTOWN, PA		
23a. Part I. Enter the disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEPSIS Due to (or as a consequence of): b. Primitive Neuroectodermal Tumor Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1 day		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier 		29c. License number DO053215		29d. Date signed (Month, Day, Year) AUGUST 10, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WYNNIE MORRISON, 600 N. WOLFE ST, BALTIMORE MD 21287		31. Date filed (Month, Day, Year) AUG 19 2000		
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26411

amend item 24a per phys. G786 8/230/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Terence Hawkes</i>				2. Date of Death Month <i>August</i> Day <i>2</i> Year <i>2000</i>		3. Time of Death <i>0530</i>	
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>				4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>319-30-4256</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>68</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>April 21, 1932</i>	
	9. Birthplace (State or Foreign Country) <i>England</i>		10a. State <i>Maryland</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Ellicott City</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>9910 Carrigan Dr.</i>		10f. Zip Code <i>21042</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>Korea</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4or 5+) <i>4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Actuary</i>		16b. Kind of Business/Industry <i>Social Security Admin.</i>				
17. Father's Name (First, Middle, Last) <i>Frank Hawkes</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Kitty Veart</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Ramsay Hawkes / spouse</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9910 Carrigan Dr. Ellicott City, MD. 21042</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		20c. Location - City or Town, State <i>Catonsville, Maryland</i>		20d. Date <i>Aug. 3 2000</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Metastatic Adenocarcinoma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>050728</i>		29d. Date signed (Month, Day, Year) <i>August 3, 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>11055 Little Patuxent Pkwy Columbia MD 21044</i>								
31. Date filed (Month, Day, Year) <i>AUG 04 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26412

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELAINE E. JONES				2. Date of Death Month 08 Day 07 Year 00		3. Time of Death 1350	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 220-32-5827		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) July 16, 1938	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster	
10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 3700 Ridge Road		10f. Zip Code 21157		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary		16b. Kind of Business/Industry Physicians Office		17. Father's Name (First, Middle, Last) Lawrence Clifton Magruder		
18. Mother's Name (First, Middle, Maiden Surname) Evelyn Viola Fox		19a. Informant's Name/Relationship (Type, Print) James D. Jones - Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 Ridge Road, Westminster, Maryland 21157		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Date 8/11/00		20d. Location - City or Town, State Rockville, Maryland		21. Signature of Funeral Service Licensee Robert L. Williams		
22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland		22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland		22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland		22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SUBARACHNOID/INTRA VENTRICULAR BLEED Due to (or as a consequence of): ANEURYSM Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year) 8/11/00		
28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Robert L. Williams		29c. License number AU4176435E12450		29d. Date signed (Month, Day, Year) 8/7/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Rami University of Maryland Hospital, Baltimore, Maryland		31. Date filed (Month, Day, Year) AUG 09 2000		32. Registrar's Signature B. Rami		33. Registrar's Signature B. Rami		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26413

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Jankowiak		2. Date of Death Month August Day 7 Year 2000		3. Time of Death 11:50 PM
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
Funeral Director	5. Social Security Number 070-09-6352	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug. 14, 1908		9. Birthplace (State or Foreign Country) New York		
Usual Residence of Decedent					
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1578 Carey Place			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry M. Wile Company
17. Father's Name (First, Middle, Last) Frank Jankowiak			18. Mother's Name (First, Middle, Maiden Surname) Catherine Cieslak		
19a. Informant's Name/Relationship (Type, Print) Joseph H. Wisniewski (Nephew)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1578 Carey Place, Frederick, Maryland 21701		
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 8/9/00	20c. Location - City or Town, State Smithsburg, Maryland
21. Signature of Funeral Service Licensee <i>Robert E. Dailey</i>			22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701		
23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest.					
Immediate Cause (Final disease or condition resulting in death) pneumonia (lobar)					
Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Approximate Interval Between Onset and Death 20 days					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic dementia (severe) Alzheimer's disease					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier George I. Smith, M.D. JPHM		29c. License number D10587		29d. Date signed (Month, Day, Year) 8/9/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George I. Smith, M.D. Vice-pres Medical Affairs Frederick Memorial Hospital Frederick, MD; 21701					
31. Date filed (Month, Day, Year) AUG 10 2000		32. Registrar's Signature <i>Benjamin B. Sparks</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Items 4c, 20b per F.D.State of Maryland / Department of Health and Mental Hygiene
08/04/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 26414

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Magdalene E Kipke				2. Date of Death Month 08 Day 03 Year 2000		3. Time of Death 6:15 AM		
	4a. Facility Name (If not institution, give street and number) 2034 Arrington Road				4b. City, Town, or Location of Death Marriottsville		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 217-05-7507		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 23, 1917	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Marriottsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 2034 Arrington Road				10f. Zip Code 21104		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic				
	17. Father's Name (First, Middle, Last) George A. Jaeger				18. Mother's Name (First, Middle, Maiden Surname) Grace Zepp				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (spouse) Mr. Richard J. Kipke, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2034 Arrington Road Marriottsville, MD 21104				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State Sykesville, MD		20d. Date 8/8/2000		
	21. Signature of Funeral Service Licensee Brian D. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CVA / Stroke Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 5 min 5 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Breast Cancer							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury NA M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred NA	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Brian D. Haight MD		29c. License number D0053115		29d. Date signed (Month, Day, Year) 08/03/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff Landman M.D. 680 Georgetown Blvd Eldersburg MD 21744									
State Registrar	31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature [Signature]						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26415

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IRMA DELORES KARANDJEFF		2. Date of Death Month Day Year AUGUST 5, 2000		3. Time of Death 11:45 AM
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
Funeral Director	5. Social Security Number 348-16-9674	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 23, 1925	9. Birthplace (State or Foreign Country) Illinois
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location New Market		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 11713 Barnswallow Place		10f. Zip Code 21774		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self		16b. Kind of Business/Industry artist		
	17. Father's Name (First, Middle, Last) Clarence Windsor Goodwin		18. Mother's Name (First, Middle, Maiden Surname) Viva Delores Neville		
	19a. Informant's Name/Relationship (Type, Print) Karen Carrier, daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5005 Killen Court, Monrovia, Maryland 21770		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State Smithsburg, Maryland
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Ryan M. Berger		22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBRAL VASCULAR ACCIDENT Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation, Hypertension				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier [Signature]		29c. License number DZ1936		29d. Date signed (Month, Day, Year) 8/7/00
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DONELSON MD 170 THOMAS JOHNSON DR, SUITE 100, FREDERICK MD 21702				
	31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature [Signature]		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26416

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH KERN				2. Date of Death Month 8 Day 3 Year 2000		3. Time of Death 1005 PM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 227-15-7502		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 28 Yrs.		8. Date of Birth (Month, Day, Year) NOV 19, 1971	
	9. Birthplace (State or Foreign Country) W. Va.		10a. State Md.		10b. County Frederick		10c. City, Town or Location Brunswick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 537 Brunswick Street		10f. Zip Code 21716		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Duct Worker		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Raymond Rucker Kern Jr.				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Patricia Werking			
	19a. Informant's Name/Relationship (Type, Print) C. Patricia Kern, Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 537 Brunswick St. - Brunswick, MD 21716			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 8/5/2000 Hagerstown, MD			
	21. Signature of Funeral Service Licensee Burlana A. William				22. Name and Address of Facility John T. Williams Funeral Home Brunswick, MD 21716			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHOLANGITIS Due to (or as a consequence of): b. PANCREATIC BLASTOMA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 DAYS 8 MONTHS							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Walter Y. Kern MD				29c. License number P13386		29d. Date signed (Month, Day, Year) 8/3/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILBUR KUD, 32 SOUTH GREENE STREET, BALTIMORE, MD 21201								
State Registrar	31. Date filed (Month, Day, Year) AUG 07 2000				32. Registrar's Signature B. Spence			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26417

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Kauffman, Sr.				2. Date of Death Month Day Year August 2 2000		3. Time of Death 2:10 a.m.	
	4a. Facility Name (If not institution, give street and number) 169 Fairfield Drive				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-54-3587		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) 4-25-51	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 169 Fairfield Drive		10f. Zip Code 21702		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Receiver		16b. Kind of Business/Industry Produce		17. Father's Name (First, Middle, Last) Leonard Napoleon Kauffman	
	18. Mother's Name (First, Middle, Maiden Surname) Frances Pauline Keeney Kauffman		19a. Informant's Name/Relationship (Type, Print) Janet Kauffman/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 169 Fairfield Drive Frederick Maryland 21702		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Hill Cemetery 8-5-00		20c. Location - City or Town, State Monrovia, Maryland		21. Signature of Funeral Service Licensee Jaqueline L. Kueh		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic rectal cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 8 m		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier E. Hamy MD	
	29c. License number D 48184		29d. Date signed (Month, Day, Year) Aug 2, 00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E Hamy ESKander MD 501 W 7th Street Frederick MD 21701		31. Date filed (Month, Day, Year) AUG 04 2000	
State Registrar	32. Registrar's Signature B. Spack		33. Date of Death (Month, Day, Year) AUG 04 2000		34. Date of Death (Month, Day, Year) AUG 04 2000		35. Date of Death (Month, Day, Year) AUG 04 2000	

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-0008.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26418

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blanche May Lucas

2. Date of Death

Month Day Year
Aug. 6, 2000

3. Time of Death

10:30 PM

4a. Facility Name (If not Institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

219-78-4232

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 10, 1922

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Keymar

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11430 Renner Rd.

10f. Zip Code

21757

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Kirby Ashby Printz

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Pearl Dodson

19a. Informant's Name/Relationship (Type, Print)

Mary M. Chapman (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11430 Renner Rd., Keymar, MD. 21757

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

8/9

20c. Location - City or Town, State

Frederick, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson FuneralHome

31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonitis

Approximate Interval Between Onset and Death

Few days.

Due to (or as a consequence of):

b.

Chronic Obstructive Pulmonary Disease

Few years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.V.A. Dehydration, Subacute Bowel obstruction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 518063

29d. Date signed (Month, Day, Year)

8/8/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABDUL MAJED 801 TOLL HOUSE AVE FREDERICK MD 21701

31. Date filed (Month, Day, Year)

AUG 08 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural," or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26419

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Marie Merrihew				2. Date of Death Month August Day 6 Year 2000		3. Time of Death 4:32 a.m.	
	4a. Facility Name (If not Institution, give street and number) 5615 Glen Hill Court				4b. City, Town, or Location of Death Jefferson		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 102-16-2830		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) April 11 1916	
	9. Birthplace (State or Foreign Country) Yukon, PA		10a. State MD		10b. County Frederick		10c. City, Town or Location Jefferson	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 5615 Glen Hill Court		10f. Zip Code 21755	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Housewife			
	17. Father's Name (First, Middle, Last) Michael Myers				18. Mother's Name (First, Middle, Maiden Surname) Johanna Cochran			
	19a. Informant's Name/Relationship (Type, Print) Bruce J. Merrihew, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615 Glen Hill Court, Jefferson, MD 21755			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State 8/9/00 Petersville, MD	
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Excessive Alcohol Due to (or as a consequence of): Breast Ca -> Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Long a liver Due to (or as a consequence of): 2 mo				Approximate Interval Between Onset and Death 2 mo			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier [Signature]				
29c. License number D14622				29d. Date signed (Month, Day, Year) Aug 8, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. [Signature]				31. Data filed (Month, Day, Year) Aug 8 2000				
32. Registrar's Signature [Signature]				33. Registrar's Signature [Signature]				


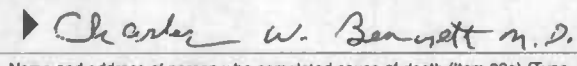

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26420

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Lou Overton				2. Date of Death Month Day Year Aug 3 2000				3. Time of Death 120 am		
	4a. Facility Name (If not institution, give street and number) Asbury Solomons Heath Care Center				4b. City, Town, or Location of Death Solomons				4c. County of Death Calvert		
Funeral Director	5. Social Security Number 450 28 6707		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Dec 23 1911		9. Birthplace (State or Foreign Country) Texas		
	10a. State Maryland				10b. County Calvert		10c. City, Town or Location Solomons		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 11100 Asbury Circle				10f. Zip Code 20688				10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 +				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife				16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Jerry Boone Johnson				18. Mother's Name (First, Middle, Maiden Surname) Mary Carey							
19a. Informant's Name/Relationship (Type, Print) Carey O. Randall -daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 596 Lake Dr. Lusby MD 20657							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Walker Chapel				Date Aug 4, 2000		20c. Location - City or Town, State Arlington Virginia	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				e. pneumonia Due to (or as a consequence of):				Approximate Interval Between Onset and Death 1 week			
b. Due to (or as a consequence of):				c. Due to (or as a consequence of):				d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D 25156		29d. Date signed (Month, Day, Year) August 3, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Bennett, M.D. HG Trueman Rd. Lusby MD 20657											
31. Date filed (Month, Day, Year) AUG 03 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26421

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT WILEY PALMER

2. Date of Death

August 5 2000

3. Time of Death

10:10 pm

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

543-10-9762

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 20 1919

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2 White Sail Circle

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1936-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ship's writer

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Martin H. Palmer

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Campbell

19a. Informant's Name/Relationship (Type, Print)

Barbara Lee Palmer-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 White Sail Circle, Berlin MD 21811

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

8-7-2000

20c. Location - City or Town, State

Salisbury Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Howard

22. Name and Address of Facility

Thomas Funeral Home PA

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Seconds - Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Years

c. Coronary Artery Disease

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Amy Almah

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☒ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John W. Smith

29c. License number

044069

29d. Date signed (Month, Day, Year)

08-09-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J ANDREWS MD 106 MILFORD RD 605 SALISBURY MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

AUG 09 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

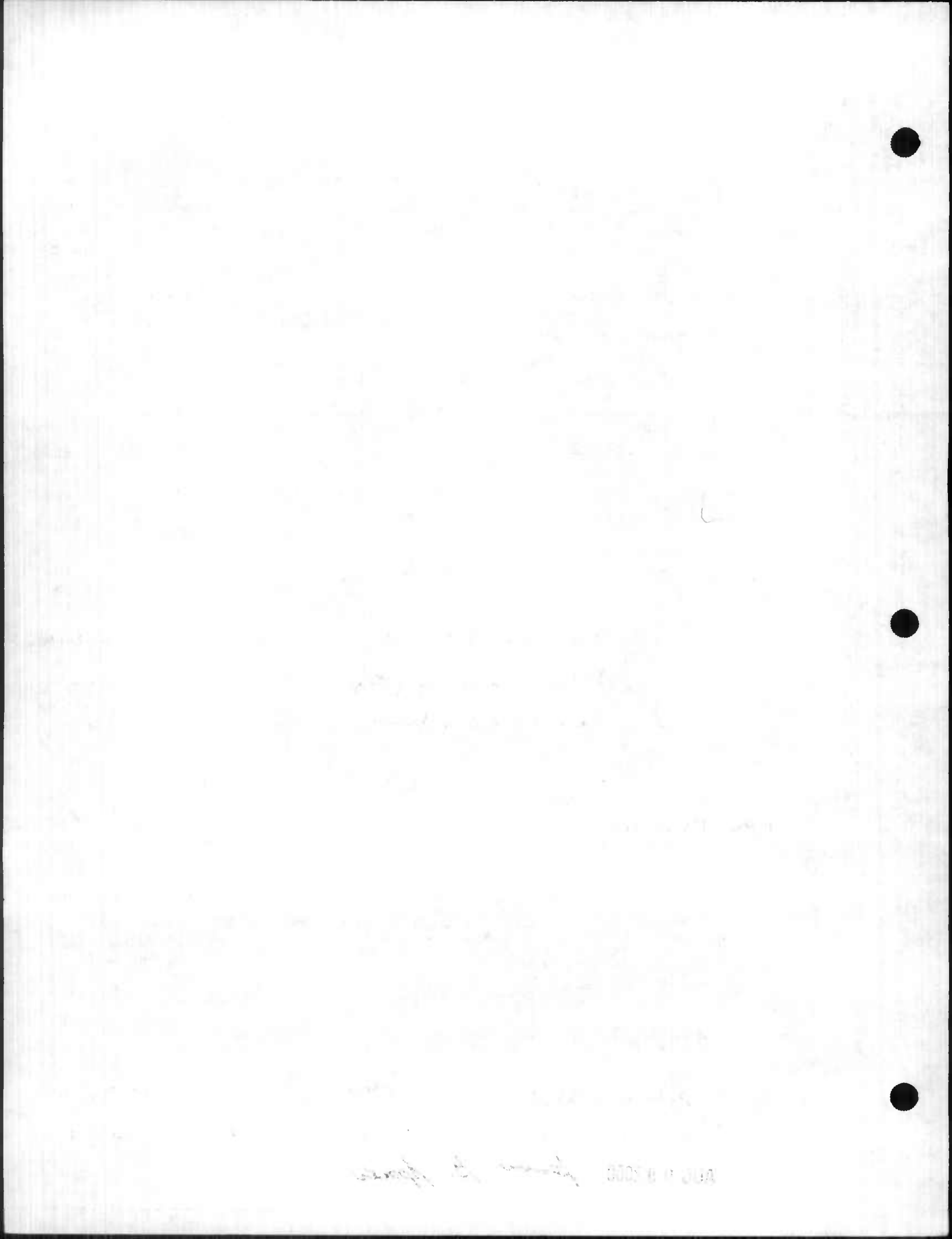
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26422

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lewis Howard Putman				2. Date of Death Month August Day 6 Year 2000		3. Time of Death 8:10 a.m.	
	4a. Facility Name (If not institution, give street and number) College View Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-26-8978	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 5, 1930		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick	
To Be Completed by Funeral Director	10e. Street and Number 403 Lee Place				10f. Zip Code 21702		10g. Citizen of What Country? United States	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 51-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) maintenance		16b. Kind of Business/Industry Oil company	
	17. Father's Name (First, Middle, Last) Lester William Putman				18. Mother's Name (First, Middle, Maiden Surname) Viola K. Hahn			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathy Cioffi / sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 Willowsdale Dr., Apt. 13, Frederick, MD 21702			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens		Date 8/8/00		20c. Location - City or Town, State Frederick, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Jaqueline R. Krebs				22. Name and Address of Facility Stauffer Funeral Homes. P.A. 1621 Opossumtown Pike, Frederick, MD 21702			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Multiple pulmonary emboli Due to (or as a consequence of): b. Diabetic mellitus, T Due to (or as a consequence of): c. Coronary heart disease Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1-2 wks 1-2 m 1-2 yrs			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. Robert S. Hughes		29c. License number DO 5111		29d. Date signed (Month, Day, Year) Aug 7, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Hughes 700 Montclair Ave. Frederick, MD 21701							
State Registrar	31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature B. Sparks					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26423

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vida Joyce Poling (AKA, Joyce Smith Poling)

2. Date of Death

August 3, 2000

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

Glade Valley Nursing Home

4b. City, Town, or Location of Death

Walkersville

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

579-40-9945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 3, 1926

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15310 Pine Orchard Drive, Apt 3J

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

elementary school teacher

16b. Kind of Business/Industry

public school system

17. Father's Name (First, Middle, Last)

William Harry Smith

18. Mother's Name (First, Middle, Maiden Surname)

Sara Helen Miller

19a. Informant's Name/Relationship (Type, Print)

Harry Poling, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 Mountain Lane, Knoxville, Maryland

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Smithsburg Crematory

Date

8/3/2000

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Ryan M. Beyer MO0999

22. Name and Address of Facility

Keeney and Basford Funeral Home

106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Due to (or as a consequence of):

Cerebrovascular accident

Approximate

Interval Between

Onset and Death

5 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)2 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allen J. Gibson MD

29c. License number

D 26516

29d. Date signed (Month, Day, Year)

August 3 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Gibson MD 1475 TANNEY AVE FRED MD 21702

31. Date filed (Month, Day, Year)

AUG 08 2000

32. Registrar's Signature

B. Spack

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26424

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward V. Reikert

2. Date of Death

Month Day Year
July 15, 2000

3. Time of Death

5:30 P.M.

4a. Facility Name (If not institution, give street and number)

Heartfields Assisted Living

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

052-03-8183

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 8, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12813 Belhurst Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Bank Examiner

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Frederick Riekert

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Ehrler

19a. Informant's Name/Relationship (Type, Print)

Edward G. Riekert

son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12813 Belhurst Lane, Bowie, Md. 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

07-17-00

20c. Location - City or Town, State

Alexandria, VA.

21. Signature of Funeral Service Licensee

Kyle Simons

M01206

22. Name and Address of Facility

Beall Funeral Home

6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D34403

29d. Date signed (Month, Day, Year)

07-17-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Dobin

4000 Mitchellville Rd., Bowie, Md. 20716

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26425

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Robin Germaine Smith

2. Date of Death

Aug. 04 2000

3. Time of Death

12:03 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center Baltimore

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

220-78-0656

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 30, 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

924 High Street

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Production Line Worker Manufacturing

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Russell Smith

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Wallace

19a. Informant's Name/Relationship (Type, Print)

Russell Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5211 Moravia Road (Apt. H) Baltimore, MD. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Aineys Cemetery 8/12/2000 Aineys, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME P.A.
510 Washington St Cambridge, MD. 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Chronic Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chinghe Champing
CHAMPING 2000 W Baltimore Baltimore

29c. License number

D32263

29d. Date signed (Month, Day, Year)

8/8/2000

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

CHAMPING 2000 W Baltimore Baltimore

31. Date filed (Month, Day, Year)

AUG 09 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26426

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rennie William Shreves				2. Date of Death Month Day Year Aug 2, 2000		3. Time of Death 04:30pm	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 214-05-5799		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Apr 17, 1910	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) WV		10. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		10d. Inside City Limits		
10a. Street and Number 1 Baltimore Street				10f. Zip Code 21502		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator		16b. Kind of Business/Industry Shreves Arco		
17. Father's Name (First, Middle, Last) William Harrison Shreves				18. Mother's Name (First, Middle, Maiden Surname) Dellie Teter				
19a. Informant's Name/Relationship (Type, Print) Charles Shreves son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Steeplehill Drive; Las Vegas, NV 89117				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glendale Cemetery		20c. Location - City or Town, State 8/08/ Flintstone, MD		
21. Signature of Funeral Service Licensee James F. Scarpetti				22. Name and Address of Facility Scarpetti Funeral Home P.A. Cumberland, Maryland 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic Shock caused by Aspiration								
23b. Approximate Interval Between Onset and Death 12 Hrs.								
23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Renal Failure due to Dehydration								
23d. Approximate Interval Between Onset and Death 12 Hrs.								
23e. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier D. S. B. M.D.		29c. License number D23334		29d. Date signed (Month, Day, Year) Aug 3, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dinesh Shah M.D. 625 Kent Avenue Cumberland MD 21502								
31. Date filed (Month, Day, Year) AUG 04 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

ORIGINAL

[Faint handwritten notes at the bottom of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26427

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA Louise STRADLEY			2. Date of Death Month Day Year AUGUST 7, 2000		3. Time of Death 0345 am		
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert Co.		
Funeral Director	5. Social Security Number 577-28-3468		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 9, 1919	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State MD		10b. County Calvert Co.		10c. City, Town or Location Owings	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3680 Chaneyville Road		10f. Zip Code 20736		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Telecommunications		17. Father's Name (First, Middle, Last) Milton Joseph Clement	
	18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Brunett		19a. Informant's Name/Relationship (Type, Print) Lynn Barton (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3680 Chaneyville Road Owings, MD 20736		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		20c. Date Aug. 9, 2000		20d. Location - City or Town, State Clinton, MD		21. Signature of Funeral Service Licensee	
	22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd. Owings, MD 20736		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): URINARY TRACT INFECTION		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury NA M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred NA	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA		28f. Location (Street and Number or Rural Route Number, City or Town, State) NA		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Stephen Cafferty, M.D.	
	29c. License number H37228 MD		29d. Date signed (Month, Day, Year) 8/8/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. STEPHEN CAFFERTY, M.D. PRINCE FREDERICK, MD 20678		31. Date filed (Month, Day, Year) AUG 09 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature Anna S. Sparks		33. Date of Death (Month, Day, Year) AUG 09 2000		34. Date of Death (Month, Day, Year) AUG 09 2000		35. Date of Death (Month, Day, Year) AUG 09 2000	
	36. Date of Death (Month, Day, Year) AUG 09 2000		37. Date of Death (Month, Day, Year) AUG 09 2000		38. Date of Death (Month, Day, Year) AUG 09 2000		39. Date of Death (Month, Day, Year) AUG 09 2000	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

SHERMAN VINCENT SPRIGGS

AMEND ITEMS: #23 PART I, 27 PER MEO ^{6786-8-29-00 WR.} Certificate of Death

Reg. No.

00 26428

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sherman Spriggs, Jr.		2. Date of Death Month Day Year AUG. 4, 2000		3. Time of Death 0405 AM	
	4e. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER		4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 212-84-6480	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 9, 1963
	9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent						
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Owings		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. Street and Number 806 W. Chesapeake Beach Road			10f. Zip Code 20736		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction	
17. Father's Name (First, Middle, Last) Sherman Spriggs, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Helen Spencer			
19a. Informant's Name/Relationship (Type, Print) Helen Spriggs/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 W. Chesapeake Beach Rd. Owings, MD			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Spriggs' Cemetery		Date 8/10/00		20c. Location - City or Town, State Dunkirk, MD
21. Signature of Funeral Service Licensee Blades A. Sewell			22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDITIS Due to (or as a consequence of): a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Joseph Pestaner M.D.			29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) AUG. 4, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) AUG 07 2000		32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26429

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Edward Smith

2. Date of Death

August 8 2000

3. Time of Death

4:05 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

317-30-5107

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 24, 1931

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4298 Molesworth Terrace

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Walter W. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Zenna Lindsay

19a. Informant's Name/Relationship (Type, Print)

Carol L. Smith - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4298 Molesworth Terrace, Mount Airy, Maryland 21771

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

8/11/00

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872-011723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

40 min

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 10587

29d. Date signed (Month, Day, Year)

8/8/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GEORGE I. SMITH, M.D., VICE PRES MEDICAL AFFAIRS

FREDERICK MEMORIAL HOSP.
FREDERICK, MD. 21701

31. Date filed (Month, Day, Year)

AUG 09 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26430

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BENJAMIN STRONG		2. Date of Death Month Day Year August 6, 2000		3. Time of Death 12:48 PM
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 061-09-6537	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 10, 1916		9. Birthplace (State or Foreign Country) New York		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Frederick
	10c. City, Town or Location Mount Airy		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. Street and Number 13516 Golf Club Court		10f. Zip Code 21771		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College Professor
	16b. Kind of Business/Industry County College		17. Father's Name (First, Middle, Last) Reuben Stoloff		18. Mother's Name (First, Middle, Maiden Surname) Rose
	19a. Informant's Name/Relationship (Type, Print) Roger Strong / son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13516 Golf Club Court/ Mount Airy, MD 21771		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens		20c. Location - City or Town, State Frederick, Maryland
	20d. Date 8-9-00		21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>		
	22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)				
	a. Acute Myocardial Infarction Due to (or as a consequence of):				years
	b. Coronary Artery Disease Due to (or as a consequence of):				years
	c. Diabetic Mellitus Due to (or as a consequence of):				years
To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Relatively Recent Cerebral Infarct				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>Brett Gamma, M.D.</i>		29c. License number 51980		29d. Date signed (Month, Day, Year) August 8, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brett Gamma / 9901 Medical Center Dr., Rockville, MD 20850				
State Registrar	31. Date filed (Month, Day, Year) AUG 09 2000		32. Registrar's Signature <i>B. Gamma</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #27 PER HY G788 10-25-00 WR.

State of Maryland / Department of Health and Mental Hygiene

00 26431

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID STEFANYE				2. Date of Death Month 7 Day 30 Year 00		3. Time of Death 23:50	
	4a. Facility Name (If not institution, give street and number) 30 Leslie Muse				4b. City, Town, or Location of Death Ocean Pines		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 088-20-6501		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) 5/7/1926	9. Birthplace (State or Foreign Country) PA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County Worcester		10c. City, Town or Location Ocean Pines		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 30 Leslie Muse				10f. Zip Code 21811		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Scientist		16b. Kind of Business/Industry U.S. Army			
	17. Father's Name (First, Middle, Last) Joseph Stefanye				18. Mother's Name (First, Middle, Maiden Surname) Anna Majthenyi			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marilyn Stefanye/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Leslie Muse Ocean Pines, MD 21811			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crematory 7/31/00 Frankford, DE		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diabetes Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>[Signature]</i> Joseph S. Criswell MD				29c. License number 1250255		29d. Date signed (Month, Day, Year) 7/30/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph S. Criswell MD Atlantic General Hospital 9733 Healthway Dr. Berlin, MD 21811								
31. Date filed (Month, Day, Year) AUG 01 2000				32. Registrar's Signature <i>[Signature]</i>				

STEFANYE, DAVID EXP 7/30/00 @ 2350 088-20-6501

WR. 60 RC. Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

amend item 1 per phys. G787 9/14/00 yf

00 26432

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) <u>Earl Eugene Smith</u>		2. Date of Death Month <u>09</u> Day <u>05</u> Year <u>2000</u>		3. Time of Death <u>12 30 P</u>
4a. Facility Name (If not institution, give street and number) <u>HARFORD MEMORIAL</u>		4b. City, Town, or Location of Death <u>Havre de Grace</u>		4c. County of Death <u>Harford</u>
5. Social Security Number <u>219-28-3841</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>70</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>Dec. 13, 1929</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
Usual Residence of Decedent				
10a. State <u>Maryland</u>	10b. County <u>Harford</u>	10c. City, Town or Location <u>Street</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <u>321 Blue House Road</u>		10f. Zip Code <u>21154</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <u>1951-53</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u></u>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Mechanic</u>		16b. Kind of Business/Industry <u>Automobile</u>		
17. Father's Name (First, Middle, Last) <u>Ralph Tucker Smith</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Carrie Elsie Price</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Darlene Smith / Daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>234 Wilson, Havre de Grace, MD 21078</u>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>ST. James UAME cemetery</u>		20c. Location - City or Town, State <u>8/10/00 Darlington, Maryland</u>
21. Signature of Funeral Service Licensee <u>Lisa M. Scott</u>		22. Name and Address of Facility <u>Lisa M. Scott Funeral Services</u> <u>552 Lewis Street, Havre de Grace, MD 21078</u>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>HEPATORENAL SYNDROME</u> <u>LUNG CANCER</u> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES, PNEUMONIA.</u>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <u>Matt Wachsman</u>		29c. License number <u>D40922</u>		29d. Date signed (Month, Day, Year) <u>8/5/2000.</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DR. MATT WACHSMAN 407 S. Union Ave Havre de Grace, MD 21078</u>				
31. Date filed (Month, Day, Year) <u>AUG 08 2000</u>		32. Registrar's Signature <u>B. Sparks</u>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26433

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VERONICA JEAN WILLIAMS				2. Date of Death Month Day Year AUGUST 3, 2000				3. Time of Death 08:49	
	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death PRINCE FREDERICK				4c. County of Death CALVERT	
Funeral Director	5. Social Security Number 385 38 9789		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) OCTOBER 9, 1942		9. Birthplace (State or Foreign Country) MICHIGAN		10a. State MARYLAND		10b. County CALVERT		10c. City, Town or Location LUSBY	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 12237 CONCHO COURT				10f. Zip Code 20657				10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER				16b. Kind of Business/Industry FOOD SERVICE	
	17. Father's Name (First, Middle, Last) ARNOLD RAY COATS				18. Mother's Name (First, Middle, Maiden Surname) RUTH DORIS GREGG					
	19a. Informant's Name/Relationship (Type, Print) VICKY M. POLECK / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12237 CONCHO COURT, LUSBY, MARYLAND 20657					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 8/7/00				20c. Location - City or Town, State ALEXANDRIA, VIRGINIA	
	21. Signature of Funeral Service Licensee Charles F. Bell				22. Name and Address of Facility RAUSCH FUNERAL HOME, P.A. 4405 BROOMES ISLAND ROAD, PORT REPUBLIC, MD 20676					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier David J. Tardio MD				29c. License number D47610		
29d. Date signed (Month, Day, Year) AUGUST 4, 2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID TARDIO, PRINCE FREDERICK, MD 20678										
31. Date filed (Month, Day, Year) AUG 07 2000				32. Registrar's Signature B. Jones						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26434

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Anthony Wood

2. Date of Death

August 1, 2000

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

422-56-3539

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 31, 1945

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8796 Victory Court

10f. Zip Code

21793

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1977-1990

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Radiation Waste Manager

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Charles William Wood

18. Mother's Name (First, Middle, Maiden Surname)

Louise Talley Miller

19a. Informant's Name/Relationship (Type, Print)

Maria Angela Wood /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8796 Victory Ct. Walkersville, MD 21793

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Crematory

Date

8/2/00

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility Licensee

Skkot Cody
604 Admiral Dr. #451 Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pericardial Tamponade

Due to (or as a consequence of):

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Non Small cell Cancer of the Lung

Due to (or as a consequence of):

Months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M. Tolino MD (M. Tolino)

29c. License number

MD 51610

29d. Date signed (Month, Day, Year)

8-2-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1475 Toney Ave Suite 204 Frederick MD 21702

State
Registrar

31. Date filed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26435

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA JEAN YARUSH				2. Date of Death Month Day Year AUGUST 3, 2000				3. Time of Death 7:25 p.m.			
	4a. Facility Name (If not institution, give street and number) 12513 ALGONQUIN TRAIL				4b. City, Town, or Location of Death LUSBY				4c. County of Death CALVERT			
Funeral Director	5. Social Security Number 577 46 1380		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 5, 1935		9. Birthplace (State or Foreign Country) WASHINGTON, D.C.			
	Usual Residence of Decedent				10a. State MARYLAND				10b. County CALVERT		10c. City, Town or Location LUSBY	
To Be Completed by Funeral Director	10e. Street and Number 12513 ALGONQUIN TRAIL				10f. Zip Code 20657				10g. Citizen of What Country? United States		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LICENSED PRACTICAL NURSE				16b. Kind of Business/Industry HEALTH CARE			
	17. Father's Name (First, Middle, Last) HOWARD L. SMITH				18. Mother's Name (First, Middle, Maiden Surname) LOUISE MAYS							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) VICTORIA L. COGHLAN / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12513 ALGONQUIN TRAIL, LUSBY, MARYLAND 20657							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY				Date 8/7/00		20c. Location - City or Town, State SUITLAND, MARYLAND	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Charles F. Bell				22. Name and Address of Facility RAUSCH FUNERAL HOME, P.A. 4405 BROOMES ISLAND ROAD, PORT REPUBLIC, MD 20676							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA OF THE LUNG Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 YEARS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Charles Bennett, M.D.				29c. License number D25156		29d. Date signed (Month, Day, Year) AUGUST 4, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES W. BENNETT, M.D., 11845 H.G. TRUEMAN ROAD, LUSBY, MARYLAND 20657											
	31. Date filed (Month, Day, Year) AUG 07 2000				32. Registrar's Signature Bennett							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26436

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George M. Armor, III				2. Date of Death Month Day Year August 20 2000		3. Time of Death 9:00AM	
	4a. Facility Name (If not institution, give street and number) 1008 Poplar Hill Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-34-1325		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 8-21-1935	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: N/A 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Merit Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1958-59	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 4 College (1-4 or 5+): 4		16. Kind of Business/Industry Armor Company - Owner Real Estate Developer	
	17. Father's Name (First, Middle, Last) George M. Armor, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Annie Linn Henley		19a. Informant's Name/Relationship (Type, Print) Mrs Christine B. Armor (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Poplar Hill Road, Baltimore, Maryland 21210	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Services Corp.		20c. Location - City or Town, State Towson, Maryland		20d. Date 8-23-00	
	21. Signature of Funeral Service Licensee Wallace S. Brooks, Jr.		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis b. Deep vein thrombosis (leg) c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 10 Years 4 Months	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Paul A. Eder MD		29c. License number B38202		29d. Date signed (Month, Day, Year) August 21, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Eder MD 21 Cassinade Drive, #330 Owings Mill, MD 21117				31. Date filed (Month, Day, Year) AUG 22 2000			
	32. Registrar's Signature James B. Sparks				33. Date of Death (Month, Day, Year) AUG 20 2000			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

G786 8-23-00 WR

Reg. No.

00 26437

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO

Certificate of Death

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Anthony Adkins

2. Date of Death

Month Day Year
August 10, 2000

3. Time of Death

1632 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-80-7477

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 10, 1959

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

233 Fridinger Mill Road

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Builder

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Charles W. Adkins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Julia Lucille Roberts

19a. Informant's Name/Relationship (Type, Print)

Charles W. Adkins, Sr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 252 Woodbine, MD 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Poplar Grove Cemetery

Date

Aug. 22
2000

20c. Location - City or Town, State

Phoenix, MD

21. Signature of Funeral Service Liaison

Michael J. Flagle

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc
10 W. Padonia Road Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

NARCOTIC AND ETHANOL INTOXICATION

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)
Found:
8-10-00

28b. Time of Injury

Found:
3:49

P

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

818 E.

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

FOUND: DWELLING

28f. Location (Street and Number or Rural Route Number,
City or Town, State)818 E. JEFFREY ST.
BALTIMORE, MD29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary G. Ripple, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPLE, M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Benjamin A. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26438

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH M ALPERT				2. Date of Death Month Day Year August 17, 2000		3. Time of Death 10:56 PM		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-14-2447		6. Sex XX M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth Month Day Year SEPT 20 1916		
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMMERCIAL ARTIST				16b. Kind of Business/Industry ADVERTISING	
17. Father's Name (First, Middle, Last) MAX ALPERT				18. Mother's Name (First, Middle, Maiden Surname) ENNIE SHERMAN					
19a. Informant's Name/Relationship (Type, Print) MRS. TRUDE ALPERT/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7218 PARK HEIGHTS AVE. APT. 308 BALTIMORE, MD. 21208					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		20c. Location - City or Town, State 8/20/00 REISTERSTOWN, MD.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiogenic shock Due to (or as a consequence of): b. Acute myocardial infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number RES 000				29d. Date signed (Month, Day, Year) August 17, 2000	
29b. Signature and title of certifier  J. Crisler D.D.									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jena CRISLER, D.D. Sinai Hospital 2401 W. Belvedere Ave. Baltimore MD								21215	
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature  J. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26439

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Hattie Asken</u>				2. Date of Death Month <u>08</u> Day <u>16</u> Year <u>2000</u>		3. Time of Death <u>1708</u>	
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>264-40-0036</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>80</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Mar 18 1920</u>	
	9. Birthplace (State or Foreign Country) <u>GA</u>		10a. State <u>MD</u>		10b. County <u>ANNE ARUNDEL</u>		10c. City, Town or Location <u>GLEN BURNIE</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>424 LINCOLN DRIVE</u>		10f. Zip Code <u>21060</u>		10g. Citizen of What Country? <u>U S A</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th</u> College (1-4or 5+) <u>NA</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEWIFE</u>		16b. Kind of Business/Industry <u>AT HOME</u>		17. Father's Name (First, Middle, Last) <u>EUGENE DINKINS</u>		
18. Mother's Name (First, Middle, Maiden Surname) <u>DOSHER DINKINS</u>		19a. Informant's Name/Relationship (Type, Print) <u>JOSEPH ASKEW - SON</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>424 LINCOLN DRIVE GLEN BURNIE, MD 21060</u>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <u>EVERGREEN CEMETERY</u>		20c. Location - City or Town, State <u>8-21-00 JACKSONVILLE, FL.</u>		21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>MARCH FUNERAL HOME WEST, INC.</u> <u>4300 WABASH AVE. BALTO., MD 21215</u>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>brain aneurysm</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Subarachnoid hemorrhage</u>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year) <u>28b. Time of Injury</u> <u>28c. Injury at Work?</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>24417643512457</u>		29d. Date signed (Month, Day, Year) <u>08/16/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>NIRAV Shah, 22 South Greene Street, Baltimore, Maryland 21201</u>		31. Date filed (Month, Day, Year) <u>AUG 22 2000</u>		32. Registrar's Signature <u>[Signature]</u>				

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Amended Item#* PERFHG787 9/8/2000 EW

Certificate of Death

Reg. No.

00 26440

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Richard Becker</u>				2. Date of Death Month <u>Aug</u> Day <u>20</u> Year <u>2000</u>		3. Time of Death <u>10:50 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Genesis Herring Hwy</u> <u>1801 Wentworth Rd</u>				4b. City, Town, or Location of Death <u>Balto</u> <u>21234</u>		4c. County of Death <u>Balto</u> <u>count</u>	
Funeral Director	5. Social Security Number <u>214-26-8288</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>71</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <u>August 13, 1929</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore City</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>6029 Old Harford Rd.</u>				10f. Zip Code <u>21214</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8yr's</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Laborer</u>			16b. Kind of Business/Industry <u>Cloverland Dairy</u>	
17. Father's Name (First, Middle, Last) <u>Richard Becker</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Katherine Chenowith Hochrein</u>				
19a. Informant's Name/Relationship (Type, Print) <u>John N. Ruth - Attorney</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>301 Halsey Road Annapolis, Maryland 21401</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parkwood Cemetery</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>		
21. Signature of Funeral Service Licensee <u>Paul E. Hentrich Jr</u>				22. Name and Address of Facility <u>Baltimore, Maryland 21214</u> <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u>				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Acute Cerebrovascular Disease</u> Due to (or as a consequence of): b. <u>Myocardial Infarction</u> Due to (or as a consequence of): c. <u>Myocardial Infarction</u> Due to (or as a consequence of): d. <u>Myocardial Infarction</u>								Approximate Interval Between Onset and Death <u>Minutes</u>
23a. Pert II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Previous History of Cancer of Sigmoid</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier <u>Dr. [Signature]</u>
29c. License number <u>008358</u>								29d. Date signed (Month, Day, Year) <u>Aug 20 2000</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Specific V. PARRICID</u> <u>8903 HARFORD ROAD BALT. HARFORD 21234</u>								
31. Date filed (Month, Day, Year) <u>AUG 22 2000</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26441

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Ellen Beahn

2. Date of Death

August 15, 2000

3. Time of Death

10:25 P.M.

4a. Facility Name (If not institution, give street and number)

Manor Care Ruxton

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

494-09-9038

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 20, 1912

9. Birthplace (State or Foreign Country)

St. Louis, MO.

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3520 Ailsa Ave.

10f. Zip Code

21214

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Martin Marrietta

17. Father's Name (First, Middle, Last)

John Scheuermann

18. Mother's Name (First, Middle, Maiden Surname)

Johanna Boland

19a. Informant's Name/Relationship (Type, Print)

Mr. James P. Beahn (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Dublin Drive Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Most Holy Redeemer Cemetery

Data

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Stroke Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D-12849

29d. Date signed (Month, Day, Year)

8-21-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.H. GHILADI, M.D., 7600 OSLER Dr. TOWSON MD. 21204

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

A.H. Ghiladi

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2024.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: # 17 PER F.H. G786 8-22-00

Certificate of Death

Reg. No.

00 26442

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Boyer				2. Date of Death Month Day Year AUGUST 20, 2000		3. Time of Death 02:05 A.M.	
	4a. Facility Name (If not institution, give street and number) 6150 FORELAND Garth Apartment 210				4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 212-30-8017		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 2/23/1916	
	10a. State MD		10b. County Howard		10c. City, Town or Location Columbia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 6150 Foreland Garth Apt 210				10f. Zip Code 21045		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) UNKNOWN PRESKE Unknown Pressly					18. Mother's Name (First, Middle, Maiden Surname) Unknown			
19a. Informant's Name/Relationship (Type, Print) Walter J. Roe Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1917 Lantana Court Virginia Beach, VA 23456				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee Robert Proctor				22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Avenue, Baltimore, Maryland 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DROWNING ASSOCIATION WITH ARTERIOSCLEROTIC Due to (or as a consequence of): b. CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) AUG 8-19-00		28b. Time of Injury 2336P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred DROWNED IN BATHTUB -					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 6150 FORELAND GARTH COLUMBIA MD			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Maurice Melville MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. K. KOSOW 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature B. Sparks				

ORIGINAL

mmmr

Charles E. Beckles

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26443

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Beckles, Jr.		2. Date of Death Month August Day 19 Year 2000		3. Time of Death 1815 pm
	4a. Facility Name (If not institution, give street and number) Bon Secour Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 214-58-5526	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 20, 1953		9. Birthplace (State or Foreign Country) Md.		
Usual Residence of Decedent					
10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10a. Street and Number 1702 N. Fulton Avenue			10f. Zip Code 21217		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry Rockwell's Restaurant
17. Father's Name (First, Middle, Last) Charles E. Beckles, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Louise Blake		
19a. Informant's Name/Relationship (Type, Print) Brenda L. Thomas sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5756 Cedonia Avenue Apt. F Baltimore, Md. 21206		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date Aug. 24
20c. Location - City or Town, State Baltimore, Md.					
21. Signature of Funeral Service Licensee Ernest R. Gandy Jr.			22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Mayotte McShelton			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 20, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGARET A. KOBEN 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 22 2000			32. Registrar's Signature Geneva Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26444

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Viola Brown				2. Date of Death Month: August Day: 15 Year: 2000		3. Time of Death 1915 pm	
	4a. Facility Name (If not institution, give street and number) 2115 Clifton Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-54-3327		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 2, 1949	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 2115 Clifton Ave.		10f. Zip Code 21217	
	10g. Citizen of What Country? USA				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Candy Maker				16b. Kind of Business/Industry Rheb Candy Co.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William Brown				18. Mother's Name (First, Middle, Maiden Surname) Mable Barnes			
	19a. Informant's Name/Relationship (Type, Print) (son) Mr. William Fossett				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Clifton Ave. Balto, Md. 21217			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		20c. Location - City or Town, State Lansdowne, Md.	
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple blunt and sharp force injuries Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 8-15-2000		28b. Time of Injury unknown		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Subject was struck with blunt object cut and stabbed		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2115 Clifton Avenue Baltimore City, Maryland		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Stephen S. Radentz, M.D.	
	29c. License number O.C.M.E.						29d. Date signed (Month, Day, Year) August 16, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201						31. Date filed (Month, Day, Year) AUG 22 2000	
	32. Registrar's Signature As. Spahr						33. Date filed (Month, Day, Year)	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26445

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Earl L. Booth

2. Date of Death

August 20, 2000

3. Time of Death

10:10 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

137 Northdale Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

218-36-5650

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 1, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

137 Northdale Road

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

H&S Bakery

17. Father's Name (First, Middle, Last)

Earl Booth

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Cockrall

19a. Informant's Name/Relationship (Type, Print)

Susan Booth (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

137 Northdale Road Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

8/25/00

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

031551

29d. Date signed (Month, Day, Year)

August 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell R. DeLuca, 1600 S. Craig Highway, Ste 602, Glen Burnie, Md. 21061

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Reg. No.

00 26446

1. Decedent's Name (First, Middle, Last) **Dorothy Virginia Burns** 2. Date of Death **August 21, 2000** 3. Time of Death **8:00A.M.**

4a. Facility Name (If not Institution, give street and number) **Oak Lodge Assisted Living** 4b. City, Town, or Location of Death **Pasadena** 4c. County of Death **Anne Arundel**

5. Social Security Number **214-38-5005** 6. Sex **1 M 2 F** 7. Age (In yrs. last birthday) **79** Yrs. 8. Date of Birth (Month, Day, Year) **Nov. 20, 1920** 9. Birthplace (State or Foreign Country) **Virginia**

10a. State **Maryland** 10b. County **Anne Arundel** 10c. City, Town or Location **Pasadena** 10d. Inside City Limits **1 Yes 2 No**

10e. Street and Number **1520 Puffin Court** 10f. Zip Code **21122** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status **3 Widowed** 12. Was Decedent Ever in U.S. Armed Forces? **1 Yes 2 No** 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1 Yes 2 No** 14. Race - American Indian, Black, White, etc. **Specify: White**

15. Decedent's Education (Specify only highest grade completed) **12** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Housewife** 16b. Kind of Business/Industry **Home**

17. Father's Name (First, Middle, Last) **Benjamin Thomas** 18. Mother's Name (First, Middle, Maiden Surname) **Blanche Grove**

19a. Informant's Name/Relationship (Type, Print) **Robert C. Burns (Son)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1520 Puffin Court, Pasadena, Maryland 21122**

20a. Method of Disposition **1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)** 20b. Place of Disposition (Name of cemetery, crematory or other place) **Greenmount Cemetery** 20c. Location - City or Town, State **8-22-00 Baltimore, Maryland**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **3204 Mountain Rd. Pasadena McCully-Polyniak Funeral Home P.A. Md2112**

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **DEMENTIA** **MULTIPLE INFARCTS**

23b. Did tobacco use contribute to the cause of death? **1 Yes 2 No 3 Probably 4 Unknown**

24a. Was an autopsy performed? **1 Yes 2 No** 24b. Were autopsy findings available prior to completion of cause of death? **1 Yes 2 No**

25. Was case referred to medical examiner? **1 Yes 2 No** 26. Place of Death (Check only one) **Assisted Living**

27. Manner of Death **1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined** 28a. Date of Injury (Month, Day Year) **28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No** 28d. Describe how injury occurred **28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)** 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) **29b. Signature and title of certifier [Signature]** 29c. License number **021703** 29d. Date signed (Month, Day, Year) **08/21/2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **MICHAEL E. GARAHY, 8651 Ft. Smallwood Rd, Pasadena Md**

31. Date filed (Month, Day, Year) **AUG 22 2000** 32. Registrar's Signature **[Signature]**


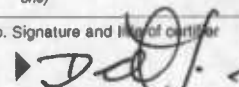
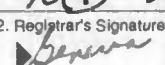
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #10E PER F.H. G786 8-22-00 ^{WR} ~~Certificate of Death~~

Reg. No.

00 26447

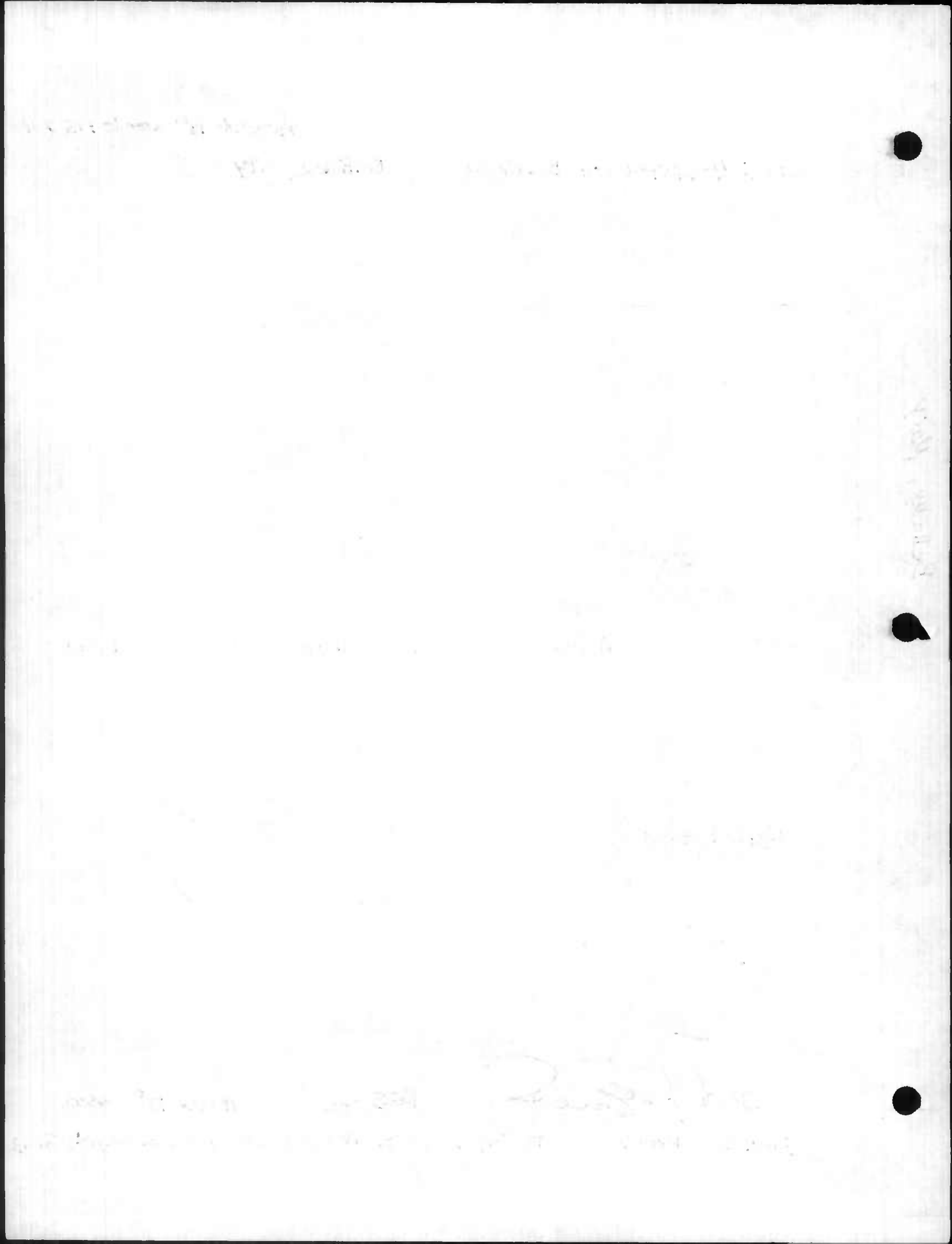
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary M. Bellamy					2. Date of Death Month August Day 18th Year 2000 10:15 PM		3. Time of Death							
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore					4b. City, Town, or Location of Death Baltimore, City		4c. County of Death							
Funeral Director	5. Social Security Number 238-48-9645		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) 07/01/1910		9. Birthplace (State or Foreign Country) North Carolina						
	Usual Residence of Decedent														
10a. State N.C.			10b. County Columbus			10c. City, Town or Location Whiteville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 456 LEGION DRIVE EXIT 465 Leigh Street					10f. Zip Code 28472		10g. Citizen of What Country? U.S.A.								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Homemaker							
17. Father's Name (First, Middle, Last) Ed Morrison					18. Mother's Name (First, Middle, Maiden Surname) Janie (Unknown)										
19a. Informant's Name/Relationship (Type, Print) Glenda Douglas / Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 W. Saratoga St., Baltimore, Maryland 21203										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Todd Cemetery #2			20c. Location - City or Town, State 08/26/00 Claredon, North Carolina							
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 1 Hour					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and Title of certifier 		29c. License number RES 000		29d. Date signed (Month, Day, Year) August 18th 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID GRAND MD 2401 WEST BELVEDERE BALTIMORE, MD 21213															
31. Date filed (Month, Day, Year) AUG 22 2000					32. Registrar's Signature 										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Bellamy, Mary
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26448

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl Blake			2. Date of Death Month Aug. Day 16 Year 2000		3. Time of Death 1:40pm	
	4a. Facility Name (If not institution, give street and number) Grivington Knoll Nursing Center			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-24-2401		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) Nov. 11, 1910	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 22 South Athol Ave.			10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GENERAL SVCS Admin FEDERAL GOVT.		16b. Kind of Business/Industry		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George Adams			18. Mother's Name (First, Middle, Maiden Surname) Rosie E. Carter			
	19a. Informant's Name/Relationship (Type, Print) FRANCES D. BLAKE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 N. BRICE ST BALTO. MD 21229			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR		20c. Location - City or Town, State CATONSVILLE, MD		
	21. Signature of Funeral Service Licensee Gloria Adams Jones		22. Name and Address of Facility MARSHALL W. JONES, JR R.H. PA 4101 Edmondson Ave. BALTO. MD 21229				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's dementia Due to (or as a consequence of): b. Atherosclerotic Cardiovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 4 yrs 4 yrs
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA						
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
State Registrar	29b. Signature and title of certifier Amatum H. Hadeem MD			29c. License number D 15503		29d. Date signed (Month, Day, Year) Aug, 18, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMATUM H. HADEEM, 501 DOLPHIN ST. BALTO, MD 21217						
	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature B. Sparks				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26449

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William E. Boyd				2. Date of Death Month August Day 21 Year 2000		3. Time of Death 5:00 AM		
	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-42-1293		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) May 11, 1943		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall		
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 9303 Waltham Woods Road		10f. Zip Code 21234		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1960		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) 12 years	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Mechanic Retirement Community		16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) Andrew Cowan Boyd		18. Mother's Name (First, Middle, Maiden Surname) Edna Mayfield		19a. Informant's Name/Relationship (Type, Print) Robert Winkler, Lawyer	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Baltimore Ave, suite 203, Towson, MD 21204		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		20c. Location - City or Town, State Baltimore City		20d. Date Aug 22, 2000	
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Brian T. Chisholm Funeral Services of Dolan & Alley 200 E. Padonia Rd. Timonium, MD 21065		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		Approximate Interval Between Onset and Death 6 months	
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 Yes 2 No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice							
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D25205		29d. Date signed (Month, Day, Year) August 21, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.R. Ley 6701 N. Charles St Balto. md 21208	
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature [Signature]							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 26450

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM F BOLDING		2. Date of Death Month Day Year AUGUST 18 2000		3. Time of Death 01:00
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL 2401 W. BELVEDERE AVE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 913-09-1093	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 102 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) August 7, 1998		9. Birthplace (State or Foreign Country) OHIO		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County BALTIMORE
	10c. City, Town or Location RANDALLSTOWN		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4320 BREEDERS CUP CIR		10f. Zip Code 21133		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER	
16b. Kind of Business/Industry MANUFACTURING		17. Father's Name (First, Middle, Last) JUNUS BOLDING		18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN	
19a. Informant's Name/Relationship (Type, Print) CAROLYN E JACKSON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4320 BREEDERS CUP CIR. BALTO MD 21133			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION		20c. Location - City or Town, State 8-2400 LANDSBOWNE, MD	
21. Signature of Funeral Service Licensee Willie S Howell		22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LEBERET HEIGHTS AVENUE BALTIMORE, MD 21207			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Justin Erickson		29c. License number 19678		29d. Date signed (Month, Day, Year) AUGUST 18, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISTIN E. ERICKSON 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215					
State Registrar	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature Beverly B Sparks		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26451

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA

COLEMAN

2. Date of Death

Month

Day

Year

AUGUST

16

2000

3. Time of Death

20:00

Funeral
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

5. Social Security Number

220-36-8862

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02-16-23

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

2138 Aiken Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Baltimore Public Sch

17. Father's Name (First, Middle, Last)

Tommie Gamble

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Harrison

19a. Informant's Name/Relationship (Type, Print)

Isaac Coleman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2138 Aiken Street Baltimore, Maryland 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Mem. Pk. Cem. 08-21-2000 Arbutus, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. RENAL FAILURE

TWO WEEKS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

TEN YEARS

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

TEN YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide ☐ Could not be determined
☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

AUGUST 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELISSA W. COSTELLO JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE

MARYLAND 21287

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
20253.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26452

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith Cuccina

2. Date of Death
Month Day Year
August 20, 20003. Time of Death
1:39 PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Caton manore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-18-3871

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 26, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1717 Jackson Street

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Paper Factory

17. Father's Name (First, Middle, Last)

John Smith

18. Mother's Name (First, Middle, Maiden Surname)

Edna Moon

19a. Informant's Name/Relationship (Type, Print)

Edna Newman- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1717 Jackson Street Baltimore, MD. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Cemetery

Date

8-23-00

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Charles L. Stevens Funeral Home Inc.
1501 E. Fort Avenue Baltimore, MD. 21230

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Non Insulin Dependent Diabetes

Approximate Interval Between Onset and Death

3 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder, Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30555

29d. Date signed (Month, Day, Year)

August 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Neal Dennis 901 East Fort Ave, Balto, MD 21230

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Cuccina Edith

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

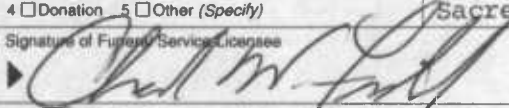
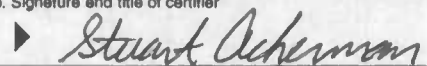
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26453

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillian Danowski				2. Date of Death Month August Day 19 Year 2000		3. Time of Death 3:30am
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 218-09-5774	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 20, 1920	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 839 Jaydee Avenue			10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) James W. Zielinski			18. Mother's Name (First, Middle, Maiden Surname) Victoria Szydloski			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Albert R. Danowski (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1342 A Sleepy Hollow Road Severn, MD 21144			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Mt. of Jesus Cem.		Date 8/22/2000	20c. Location - City or Town, State Dundalk, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death 5 Days 6 months						
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier  S.O.		29c. License number RD 198796		29d. Date signed (Month, Day, Year) 8/19/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Stuart Ackerman 9000 Franklin Square Drive Baltimore, Maryland 21237						
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26454

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERNEST DIGGS				2. Date of Death Month Day th Year AUGUST 17 th 2000		3. Time of Death 7:45 PM		
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 214-01-0572	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 1, 1914		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodlawn		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 6608 1/2 Liberty Terrace				10f. Zip Code 21207		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Afro-American		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Representative to Council U.S. Government				16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) George Grant Diggs				18. Mother's Name (First, Middle, Maiden Surname) Ethel Mildred Frye				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Anna Mae Cole (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 Liberty Terrace Woodlawn Md. 21207				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		20c. Location - City or Town, State 8/19/2000 Balto, Md.				
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE CARDIOMYOPATHY. PNEUMONIA.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Harish MD.				29c. License number D42723		29d. Date signed (Month, Day, Year) AUGUST 17 th 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVVERA HALLI M HARISH				NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133					
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature B. Spence							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

James Brandon Durham
00-4668-510
UNK 00-226
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 26455

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Brandon Durham		2. Date of Death Month AUGUST Day 17 Year 2000		3. Time of Death 11:51 P.M.	
	4e. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-04-9398		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 16 Yrs.	
	8. Date of Birth (Month, Day, Year) 11-02-83		9. Birthplace (State or Foreign Country) MD			
Usual Residence of Decedent						
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3812 Mary Avenue			10f. Zip Code 21206		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry Student	
17. Father's Name (First, Middle, Last) James R. Durham			18. Mother's Name (First, Middle, Maiden Surname) Pamela Berry			
19a. Informant's Name/Relationship (Type, Print) Pamela Reaves			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 Mary Avenue Baltimore, Maryland 21206			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. Date 08-24-2000		20d. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gunshot Wound of Chest Due to (or as a consequence of): a. _____ Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/17/00		28b. Time of Injury PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28d. Describe how injury occurred Sub, ect shot				
28f. Location (Street and Number or Rural Route Number, City or Town, State) 3400 Kentucky Ave						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 18, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Wilson Locke, MD 111 Penn Street, Baltimore, Maryland 21201						
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-7 show any injury or other traumatic event, the Medical Examiner must be notified at 000-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26456

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilbur Eugene Ensor, Sr.				2. Date of Death Month Day Year August 19, 2000		3. Time of Death 6:33PM		
	4a. Facility Name (If not institution, give street and number) 14936 Tanyard Road				4b. City, Town, or Location of Death Sparks		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 220-34-5996		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 5, 1930		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Sparks		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14936 Tanyard Road		10f. Zip Code 21152		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dairy Farmer		16b. Kind of Business/Industry Agriculture			
17. Father's Name (First, Middle, Last) Lester Chilcoat Ensor				18. Mother's Name (First, Middle, Maiden Surname) Jodie Barbara Brown					
19a. Informant's Name/Relationship (Type, Print) Wilbur E. Ensor, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 A Cockeys Mill Road Reisterstown, MD 21136					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Black Rock Cemetery		Date Aug. 22 2000		20c. Location - City or Town, State Butler, MD			
21. Signature of Funeral Service Licensee Michael J. Flagle				22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Metastatic lung cancer		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Approximate Interval Between Onset and Death > 2 years	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Ayman F. Akkad, MD		29c. License number 042736		29d. Date signed (Month, Day, Year) 8-21-2000			
30. Name and address of person who completed cause of death (Item 25a) (Type, Print) Ayman F. Akkad, MD 7600 Osler Dr. Suite 411 Towson, MD 21204		31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature Benjamin B Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26457

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVINA FISH				2. Date of Death Month Day Year AUGUST 19 2000				3. Time of Death 5:13 am				
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death n/a				
Funeral Director	5. Social Security Number 212-20-9689		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Sep 18, 1924		9. Birthplace (State or Foreign Country) Maryland				
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
10e. Street and Number 2618 Tulip Avenue		10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.									
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Bus Driver		16b. Kind of Business/Industry Baltimore County Sch.									
17. Father's Name (First, Middle, Last) John Ripley				18. Mother's Name (First, Middle, Maiden Surname) Viola Mae Souder									
19a. Informant's Name/Relationship (Type, Print) Edward H. Fish / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2618 Tulip Avenue, Baltimore, Maryland 21227									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory, Inc.		Date 8/23/2000		20c. Location - City or Town, State Baltimore, Maryland							
21. Signature of Funeral Service Licensee Quanta R Thomas		22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 15-30 min					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA, DIABETES, CONGESTIVE HEART FAILURE.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ms		29c. License number P199711		29d. Date signed (Month, Day, Year) August 19, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYA S. THEIN, 3001 SOUTH HANOVER ST. BALTIMORE. MD 21225		31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature B Spars									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

unknown 00-218
Stephen Scott Ferguson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

00 26458

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) STEPHEN SCOTT FERGUSON				2. Date of Death Month Day Year August 15, 2000		3. Time of Death 1820 pm	
	4a. Facility Name (If not institution, give street and number) 452 East 28th Street, 2nd Floor Apt.				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-82-1260	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 2, 1958		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 Yes 2 No		
10e. Street and Number 120 MacBeth Drive				10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Specialty Adjuster		16b. Kind of Business/Industry Envelope Manufacturing		
17. Father's Name (First, Middle, Last) Calvin Ferguson				18. Mother's Name (First, Middle, Maiden Surname) Bertha Johnson				
19a. Informant's Name/Relationship (Type, Print) Teresa Boston				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6120 MacBeth Drive Baltimore, Maryland 21239				
20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 8-22-2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee George J. Ferrante				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE NARCOTIC INTOXICATION								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found: 8-15-00		28b. Time of Injury Found: 6:15 P M		28c. Injury at Work? 1 Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 452 E. 28TH ST., 2ND FL. BALTIMORE, MD						
29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. M. [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 16, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) Aug 22 2000		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26459

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) William H. Gelston		2. Date of Death Month August Day 20 Year 2000		3. Time of Death 6:40PM.	
4a. Facility Name (If not Institution, give street and number) Union Memorial Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 219-16-4869	6. Sex XXM 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 11. 1924
9. Birthplace (State or Foreign Country) Illinois					
Usual Residence of Decedent					
10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 3663 Keystone Avenue		10f. Zip Code 21211		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Night Watchman		16b. Kind of Business/Industry Security	
17. Father's Name (First, Middle, Last) Hugh D. Gelston			18. Mother's Name (First, Middle, Maiden Surname) Elsie A. Stringer		
19a. Informant's Name/Relationship (Type, Print) George Gowe Brother-in-law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3663 Keystone Avenue, Baltimore, Maryland 21211			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 8/25/00 Beltsville, MD	
21. Signature of Funeral Service Licensee Lynn B. Henss		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. sepsis Due to (or as a consequence of): b. Acute respiratory failure Due to (or as a consequence of): c. hyperkalemia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 24 hours 2 hours 24 hours
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Jan Lberg MD		29c. License number AU4176435L		29d. Date signed (Month, Day, Year) August 20, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Tom Linberg MD Union Memorial Hospital, Baltimore, Maryland					
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature [Signature]			

State Registrar

ADH
DANNY GALES
00-4627-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26460

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Eugene Gales		2. Date of Death Month AUGUST Day 17 , Year 2000		3. Time of Death 1007 PM
	4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death n/a
Funeral Director	5. Social Security Number 214-88-3998	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) Oct. 27, 1962 Md.		9. Birthplace (State or Foreign Country)		
10a. State Md.		10b. County Anne Arundel		10c. City, Town or Location Linthicum	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6530 Harrison Avenue		10f. Zip Code 21090	
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) Nathaniel Gales Jr.	
18. Mother's Name (First, Middle, Maiden Surname) Mary Dailey		19a. Informant's Name/Relationship (Type, Print) Mary Gales mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6530 Harrison Avenue Linthicum Heights, Md. 21090	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery		20c. Location - City or Town, State Aug. 24 Elkridge, Md.	
21. Signature of Funeral Service Licensee Herbert E. Nutter		22. Name and Address of Facility Nutter Funeral Homes, Inc.		22. Name and Address of Facility 2501 Gwynns Falls PKWY Baltimore, Md. 21216	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Multiple gunshot wound with complications Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 9/24/99		28b. Time of Injury 2255 HR	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot		28e. Location (Street and Number or Rural Route Number, City or Town, State) 835 Jack Street Baltimore Maryland	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Theodore M. King		29c. License number OCME	
29d. Date signed (Month, Day, Year) AUGUST 18, 2000		30. Name and address of person who completed causa of death (item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) AUG 22 2000	
32. Registrar's Signature P. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26461

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Charles Grant						2. Date of Death Month August Day 20 Year 2000		3. Time of Death 3:18 Am	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 249-349704		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71		8. Date of Birth (Month, Day, Year) Jan. 11, 1929		9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4615 Poplar Grove St.				10f. Zip Code 21215		10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Afro-American		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chauffeur				16b. Kind of Business/Industry Private Family			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Robert Grant						18. Mother's Name (First, Middle, Maiden Surname) Sarah Dinkins			
	19a. Informant's Name/Relationship (Type, Print) (Sister) Mrs. Georgia A. Jones						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 Hayward Ave. Balto. Md. 21215			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest				20c. Location - City or Town, State Owings Mills, Md.			
	21. Signature of Funeral Service Licensee Joseph L. Russ				22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia								Approximate Interval Between Onset and Death	
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular accident									
Division of Vital Records, P.O. Box 68760,	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier A. Ahmed		29c. License number D39127		29d. Date signed (Month, Day, Year) 8/22/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. AHMED 821 N. Eutaw Street - Baltimore MD 21201									
State Registrar	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature B. Smith							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26462

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie Bell Green				2. Date of Death Month Day Year Aug. 11, 2000		3. Time of Death 7:30pm	
	4a. Facility Name (If not institution, give street and number) Riverview Nursing Home				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 240-32-8132		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) 10-02-10	
	9. Birthplace (State or Foreign Country) NC		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1416 May Court		10f. Zip Code 21231		
10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd. Grade College (1-4or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry various trades		
17. Father's Name (First, Middle, Last) Josh Winstead				18. Mother's Name (First, Middle, Maiden Surname) Lizzie Winstead				
19a. Informant's Name/Relationship (Type, Print) Frances Broidy				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 May Court Baltimore, Maryland 21231				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 08-17-2000		20c. Location - City or Town, State Lansdowne, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End Stage Dementia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D43725		29d. Date signed (Month, Day, Year) 8/22/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 201-109 Back River Neck Rd. Baltimore MD 21221								
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26463

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Robert Graham</i>				2. Date of Death Month <i>8</i> Day <i>16</i> Year <i>00</i>		3. Time of Death <i>21:00</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of MD Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>240-28-8074</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>10-26-24</i>	9. Birthplace (State or Foreign Country) <i>S.C.</i>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County	10c. City, Town or Location <i>BALEIMORE</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>3719 WOODBINE AVE</i>			10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>BUILDING CONTRACTOR</i>		16b. Kind of Business/Industry <i>HOME IMPROVEMENT</i>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Robert Graham, Sr</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Caroline Thompson</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>INDIA Chambers</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3412 WASHINGTON AVE, BALTO. MD 07</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT. ZION</i>		Date <i>8-23-00</i>		20c. Location - City or Town, State <i>LANDOWING, MD</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>HOWELL Funeral Home 4600 Liberty Hgts Ave, BALTO. MD 07</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>E. coli Bacteremia</i> Due to (or as a consequence of): b. <i>severe metabolic Acidosis</i> Due to (or as a consequence of): c. <i>acute renal failure.</i> Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HIV (+)</i>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>13116</i>		29d. Date signed (Month, Day, Year) <i>8/16/00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jorge Uribe University of MD med center</i>								
31. Date filed (Month, Day, Year) <i>AUG 22 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher but appears to include phrases such as "The following is a list of..." and "The first of these is...".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26464

AMENDED ITEM #18 PER FH G786 8/22/00 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS GALLOW

2. Date of Death

Month Day Year
August 18 2000

3. Time of Death

4:28 PM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

216-07-3745

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT 02 1915

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4005 EMMART AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOKKEEPER

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

ABRAHAM

GALLOW

18. Mother's Name (First, Middle, Maiden Surname)

MILLIE

POZEFSKY MOLLIE POZEFSKY

19a. Informant's Name/Relationship (Type, Print)

MRS. DELORES SCHERR/COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6811 BROOKMILL ROAD BALTIMORE, MD. 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'NAI ISRAEL CONGREGATION

Date

8/20/00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Organ system failure

Due to (or as a consequence of):

b. Gastrointestinal hemorrhage

Due to (or as a consequence of):

c. Anticoagulation

Due to (or as a consequence of):

d. Pulmonary Embolism

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Myeloma
chronic renal failure
chronic cognitive dysfunction

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D46263

29d. Date signed (Month, Day, Year)

August 19 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AYMAN YOUSSEFI MD

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

00 26465

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26466

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Genevieve L. Holden				2. Date of Death Month Day Year August 16, 2000				3. Time of Death 8:30 PM			
	4a. Facility Name (If not institution, give street and number) Manor Care-Ruxton				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 212-42-2401		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Jan 1, 1919		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 2621 A. Proctor Lane				10f. Zip Code 21234				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) John A. Farmer				18. Mother's Name (First, Middle, Maiden Surname) Ellen V. Constance							
	19a. Informant's Name/Relationship (Type, Print) Ronald Holden				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2621 A. Proctor Lane, Parkville, MD 21234							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date Aug 19 2000		20c. Location - City or Town, State Rosedale, MD					
	21. Signature of Funeral Service Licensee <i>Kendra S. Wells</i>				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, MD							
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>E. coli bladder infection</i> Due to (or as a consequence of): b. <i>urinary retention</i> Due to (or as a consequence of): c. <i>autonomic neuropathy</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>7 days.</i>											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>advanced dementia</i>											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <i>N/A</i>		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <i>D41104</i>		29d. Date signed (Month, Day, Year) <i>8-17-00</i>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DR. Ted Houk 7825 YORK Rd. Towson, Md.</i>												
31. Date filed (Month, Day, Year) <i>AUG 22 2000</i>		32. Registrar's Signature <i>[Signature]</i>										

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26467

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Billie D. Howell, Sr.		2. Date of Death Month Day Year August 19 2000		3. Time of Death 3:55 PM
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 217-38-2979	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59	8. Date of Birth (Month, Day, Year) March 24, 1941	9. Birthplace (State or Foreign Country) N. Carolina
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 8204 Peach Orchard Road		10f. Zip Code 21222		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1965-1969		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofer		16b. Kind of Business/Industry Roofing		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John Virgil Howell		18. Mother's Name (First, Middle, Maiden Surname) Ora Lee Wilcox		
	19a. Informant's Name/Relationship (Type, Print) Mrs. Roberta Howell (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8204 Peach Orchard Road Dundalk, MD 21222		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 8/23/2000		20c. Location - City or Town, State Baltimore, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION 2 HOURS Due to (or as a consequence of): b. CORONARY ARTERY DISEASE 1 YEAR Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE, HYPERTENSION HYPER LIPIDEMIA 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D47123		29d. Date signed (Month, Day, Year) August 19, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOSEPH PUTHUMANA, UNION MEM HOSP, BALTIMORE, MD 21218.					
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26468

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael L. Hendrix		2. Date of Death Month: August Day: 13 Year: 2000		3. Time of Death 03:20 A.M.
	4a. Facility Name (If not institution, give street and number) Route 68 W/B east of Vocke Road		4b. City, Town, or Location of Death Lavale		4c. County of Death Allegany
Funeral Director	5. Social Security Number 341-66-0784	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 24 Yrs.	8. Date of Birth (Month, Day, Year) 02 29 1976	9. Birthplace (State or Foreign Country) IL
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State IL	10b. County Cook	10c. City, Town or Location Midlothian		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 3642 West 147th Place		10f. Zip Code 60445		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Yard Conductor		16b. Kind of Business/Industry Railroad		
	17. Father's Name (First, Middle, Last) Cleotha Hendrix		18. Mother's Name (First, Middle, Maiden Surname) Verlena Mays		
	19a. Informant's Name/Relationship (Type, Print) Verlena Hendrix/Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12025 South Harvard, Chicago, IL 60628		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Hope Cemetery		20c. Location - City or Town, State 08 19 Chicago, IL
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228		
	23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. HEAD INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 08/13/00					
28b. Time of Injury 3:10 A.M.					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred DRIVER OF AUTO THAT STRUCK A FIXED OBJECT					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HIGHWAY					
28f. Location (Street and Number or Rural Route Number, City or Town, State) RT 68 LAVALE MD					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier J. H. Hendrix, M.D.					
29c. License number O.C.M.E.					
29d. Date signed (Month, Day, Year) August 14, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 22 2000					
32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26469

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER HERKLOTZ				2. Date of Death Month Day Year AUGUST 9, 2000		3. Time of Death 6:02 PM	
	4e. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-74-7611	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 11, 1919		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodlawn		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2166 Lorraine Ave. Woodlawn				10f. Zip Code 21207		10g. Citizen of What Country? U S A		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (14 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) Walter H. Herklotz				18. Mother's Name (First, Middle, Maiden Surname) Lillian Crutchley				
19a. Informant's Name/Relationship (Type, Print) Richard W. Herklotz Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2166 Lorraine Ave. Woodlawn, Md 21207				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park		Date 8-12-00		20c. Location - City or Town, State Baltimore, Md		
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Witzke Funeral Home 1630 Edmondson Ave. Catonsville, Md 21228				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. VENTRICULAR FIBRILLATION Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): 40 MINUTES 1 HOUR YEARS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number 047587		29d. Date signed (Month, Day, Year) AUGUST 9, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT FINE MD 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133								
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature [Signature]				

ADH

ADOLPHUS HARDING

00-4619-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26470

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ADOLPHUS JOHN HARDING

2. Date of Death

Month Day Year
AUGUST 16, 2000

3. Time of Death

1328 PM

4a. Facility Name (If not institution, give street and number)

2700 ROLLING ROAD

4b. City, Town, or Location of Death

WOODLAWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

224-38-4767

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3-14-32

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1609 WARWICK AVE

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CEMENT FINISHER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

MORRIS HARDING

18. Mother's Name (First, Middle, Maiden Surname)

LENORA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

VICKI HARDING

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

329 SCOTT ST, BALTIMORE, MD 21230

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ADOLPHUS HARDING PK 8-15-00 ADOLPHUS MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William E Howell

22. Name and Address of Facility

HOWELL FUNERAL HOME
4604 BENTLEY BLVD
BALTIMORE, MD 2120723a. Part 1. Enter the disease, or complications that caused the death. Do not include conditions such as chronic respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

MULTIPLE INJURIES

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)
8/16/00

28b. Time of Injury

1317 PM

28c. Injury at Work?

1 ☒ Yes 2 ☐ No

28d. Describe how injury occurred

CINDER BLOCK WALL FELL ON SUBJECT

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

INDUSTRIAL AREA/CONSTRUCTION SITE

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

2700 ROLLING RD. WOODLAWN, MD

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mary G. Ripple, M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 17, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Benjamin B. Spauls

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-38807

100-38807

100-38807

100-38807

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State of Maryland / Department of Health and Mental Hygiene

00 26471

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SUSIE M. JACKSON HIGGINS				2. Date of Death Month Day Year AUGUST 16 2000		3. Time of Death 9:49 pm	
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 219-32-0936		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 11-14-28	
	9. Birthplace (State or Foreign Country) SC		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4306 ROBERTSON AVE		10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAN		16b. Kind of Business/Industry MAINTENANCE			
	17. Father's Name (First, Middle, Last) AUSTIN JACKSON				18. Mother's Name (First, Middle, Maiden Surname) MARATHA O'BANNOON			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SUSIE BARNES				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 ROBERTSON AVE, BALTO, MD 21206			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Date 8-21-00		20d. Location - City or Town, State PHOENIX, AZ	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Willie E. Howell				22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY AVENUE BALTIMORE, MD 21207			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. SEPSIS Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. RENAL FAILURE Due to (or as a consequence of): d. RESPIRATORY INSUFFICIENCY				Approximate Interval Between Onset and Death 5 days 4 days 4 days 4 days			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier GULATI, MEDICAL RESIDENT			
To Be Completed by Physician/Medical Examiner	29c. License number AT 2438946		29d. Date signed (Month, Day, Year) AUGUST 16 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANGA GULATI, UNION MEMORIAL HOSPITAL, BALTIMORE, MD			
	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature Beverly S. Sparks					

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26472

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBINA

HUNTER

2. Date of Death

Month Day Year

August 17 2000

3. Time of Death

17-20

4a. Facility Name (If not institution, give street and number)

ER FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

175-24-1591

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 29, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2904 Houcks Mill Road

10f. Zip Code

21111

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Front Clerk

16b. Kind of Business/Industry

Hotel Accomodations

17. Father's Name (First, Middle, Last)

Robert

18. Mother's Name (First, Middle, Maiden Surname)

Laverick

19. Informant's Name/Relationship (Type, Print)

Mrs. Karen A. Myers (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2904 Houcks Mill Road, Monkton, Maryland 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lloyd Cemetery

Date

8/28/2000

20c. Location - City or Town, State

Ebensburg, PA

21. Signature of Funeral Service Provider

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

ATRIAL FLUTTER

MITRAL REGURGITATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Quinn Smith DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

Aug 17 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quinn Smith M.D. 728 BELAIR RD BELAIR MD 21014

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Quinn Smith

State
Registrar

Hunter, Robina

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26473

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARA CECELIA HOLZINGER				2. Date of Death Month Day Year August 20 th 2000		3. Time of Death 9.40 AM	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-07-5715		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) July 13, 1920	
	Usual Residence of Decedent		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 1324 Andre Street		10f. Zip Code 21230	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) John J. Schier				18. Mother's Name (First, Middle, Maiden Surname) Maryann Herrmann			
	19a. Informant's Name/Relationship (Type, Print) John F. Holzinger -Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615 Cliff Side Court Baltimore, MD 21225			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 8-23-00 Baltimore, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 E. Fort Avenue Baltimore, MD. 21230			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA				Approximate Interval Between Onset and Death 7 days			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
Medical Certification: To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  Anuradha B. MD				29c. License number P13470		29d. Date signed (Month, Day, Year) 08/20/2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. BODDETI, HARBOR HOSPITAL CENTER, 3001 S HANOVER STREET, BALTIMORE, MD 21225							
	31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

OB-6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26474

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHARINE LANNECK HIBBEN				2. Date of Death Month Day Year August 17, 2000		3. Time of Death 12⁰¹ AM				
	4a. Facility Name (If not institution, give street and number) BROOKE GROVE REHABILITATION AND NURSING HOME				4b. City, Town, or Location of Death SANDY SPRING		4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 578-62-8433		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 3, 1912	9. Birthplace (State or Foreign Country) OH			
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD	10b. County Montgomery	10c. City, Town or Location Sandy Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 18100 Slade School Road			10f. Zip Code 20860		10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home					
	17. Father's Name (First, Middle, Last) Arthur Phillip Lanneck				18. Mother's Name (First, Middle, Maiden Surname) Elsa Harriet Strong						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Philip C. Meade, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4328 Montgomery Avenue, Bethesda Maryland 20814						
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery		Date August 21, 2000		20c. Location - City or Town, State Port Washington, OH				
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) JUNE 30, 2000		28b. Time of Injury PM 8:00		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred FALL FROM CHAIR			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) BROOKE GROVE ASSISTED LIVING - MEADOWS III						28f. Location (Street and Number or Rural Route Number, City or Town, State) 1637 HICKORY KNOLL ROAD SANDY SPRING, MARYLAND			
29b. Signature and title of certifier ATTENDING PHYSICIAN								29c. License number D42046		29d. Date signed (Month, Day, Year) August 17, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860											
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26475

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Locke Hoffman				2. Date of Death Month Day Year August 18, 2000		3. Time of Death 11:20PM	
	4a. Facility Name (If not institution, give street and number) 514 Piccadilly Road				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 207-07-0202		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) JAN 10, 1920	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 514 Piccadilly Road		10f. Zip Code 21204	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Staff				16b. Kind of Business/Industry Charity			
	17. Father's Name (First, Middle, Last) Percy Lock				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Jenkins			
	19a. Informant's Name/Relationship (Type, Print) Philip A. Hoffman/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Piccadilly Road Towson, MD 21204			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228			
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Multi Infarct Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 18 hours 3 yrs	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)						28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier James A. Quinlan M.D.	
State Registrar	29c. License number D12990						29d. Date signed (Month, Day, Year) August 19, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Quinlan, M.D. 7801 York Road Towson, MD 21204						31. Date filed (Month, Day, Year) AUG 22 2000	
32. Registrar's Signature James A. Quinlan								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26476

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALEXANDER		2. Date of Death Month AUGUST Day 18 Year 2000		3. Time of Death 6:45AM
	4a. Facility Name (If not institution, give street and number) 6267 BRIGHT PLUME		4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD
Funeral Director	5. Social Security Number 220-35-9861	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth JULY 14 1941		9. Birthplace (State or Foreign) RUSSIA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MD	10b. County HOWARD	10c. City, Town or Location COLUMBIA		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 6267 BRIGHT PLUME		10f. Zip Code 21044		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (15 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL ENGINEER		16b. Kind of Business/Industry ENGINEERING		
	17. Father's Name (First, Middle, Last) SAMUEL		18. Mother's Name (First, Middle, Maiden Surname) SOPHYE LOKSHINA		
	19a. Informant's Name/Relationship (Type, Print) ANNA ITKIN/WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6267 BRIGHT PLUME COLUMBIA, MD. 21044		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) COLUMBIA MEMORIAL PARK		20c. Location - City or Town, State 8/20/00 COLUMBIA, MD.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21208		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Metastatic NonSmallCell Lung Cancer 8 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 00051770		29d. Date signed (Month, Day, Year) August 18 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie R Brahmer, MD Johns Hopkins Hospital, Baltimore MD 21287					
State Registrar	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26477

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jong Sik Jun

2. Date of Death

Month Day Year
August 20, 2000

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220-51-7073

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 25, 1955

9. Birthplace (State or Foreign Country)

South Korea

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

900 Eastham Court #12

10f. Zip Code

21035

10g. Citizen of What Country?

South Korea

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tailor

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Song Gi Jun

18. Mother's Name (First, Middle, Maiden Surname)

Sun Gi Hong

19a. Informant's Name/Relationship (Type, Print)

In Hee Jun / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 Eastham Ct. #12 Crofton, MD 21035

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

Aug. 22, 2000

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home P.A.

421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Malignancy of Unknown Origin

Approximate
Interval Between
Onset and Death

6 months

Due to (or as a consequence of):

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Wicks M.D.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

August 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks M.D.

301 Hospital Drive, Glen Burnie, MD, 21061

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Bernice B. Sparks

ORIGINAL

JUN. Jong
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26478

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vinie L. Knott				2. Date of Death Month August Day 18 , Year 2000		3. Time of Death 9:55 AM			
	4a. Facility Name (If not institution, give street and number) 5106 Forge Road				4b. City, Town, or Location of Death Perry Hall		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 425-54-6551		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Sept 2, 1922			
	9. Birthplace (State or Foreign Country) Mississippi		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 5106 Forge Road					
	10f. Zip Code 21128				10g. Citizen of What Country? USA					
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Sistrunk				18. Mother's Name (First, Middle, Maiden Surname) Unknown					
	19a. Informant's Name/Relationship (Type, Print) Thomas Raines Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5106 Forge Road, Perry Hall, Maryland 21128					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Date 8/22/00		20d. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Lynn B. Henss		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland 21211							
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. ischemic cardiomyopathy Due to (or as a consequence of): b. hypertensive heart disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier [Signature]		29c. License number D0047658		29d. Date signed (Month, Day, Year) 8/21/00					
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAREE KASHI 2003 Rock Spring Road Forest Hill, MD 21050									
	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature [Signature]							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26479

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William A. Kline				2. Date of Death Month August Day 18 , Year 2000		3. Time of Death 3:55 AM	
	4a. Facility Name (If not Institution, give street and number) Gilchrist Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-38-2301		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 29, 1940	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Glyndon	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 308 Central Avenue		10f. Zip Code 21071	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1965-68	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Executive				16b. Kind of Business/Industry Advantage Sales & Marketing			
	17. Father's Name (First, Middle, Last) William Calvin Kline				18. Mother's Name (First, Middle, Maiden Surname) Georgia A. Grim			
	19a. Informant's Name/Relationship (Type, Print) Sharon L. Kline - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Central Avenue; Glyndon, MD 21071			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State Sykesville, MD	
	21. Signature of Funeral Service Licensee Joseph Kellner				22. Name and Address of Facility Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung cancer				Approximate Interval Between Onset and Death 1 year			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Anthony Riley, MD				
29c. License number 025205				29d. Date signed (Month, Day, Year) August 18, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley, MD 6701 N. Charles St. Balto. Md 21204				31. Data filed (Month, Day, Year) AUG 22 2000				
32. Registrar's Signature Sparks				33. State Registrar				

ORIGINAL

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26480

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES WILLIAM KRAUSE

2. Date of Death

Month Day Year
AUGUST 16, 2000

3. Time of Death

3:00 A.M.

4a. Facility Name (If not institution, give street and number)

502 MANSFIELD COURT

4b. City, Town, or Location of Death

SEVERNA PARK

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

306-34-3778

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
DEC. 29, 1935

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERNA PARK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

502 MANSFIELD CT.

10f. Zip Code

21146

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GOVERNMENT EMPLOYEE

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

WILLIAM KRAUSE

18. Mother's Name (First, Middle, Maiden Surname)

PEARL KELLY

19a. Informant's Name/Relationship (Type, Print)

SONIA JUNE KRAUSE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

502 MANSFIELD CT., SEVERNA PARK, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

AUG. 2000

20c. Location - City or Town, State

CATONSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Burkitt's Lymphoma

Due to (or as a consequence of):

4 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35254

29d. Date signed (Month, Day, Year)

AUGUST 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLE B. MILLER, M.D.
660 N WOLFE ST BALT MD 21205

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26481

amend item 2 per phys. G786 8/22/00 yg

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence Kinsler		2. Date of Death Month Oct Day 02 Year 00		3. Time of Death 9:00am
	4a. Facility Name (If not institution, give street and number) 512 Allendale Road		4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 215-05-3111	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 10 02 09		9. Birthplace (State or Foreign Country) S.C.		
To Be Completed by Funeral Director	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 512 Allendale Road		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) na		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Laborer		16b. Kind of Business/Industry Montgomery Ward
	17. Father's Name (First, Middle, Last) John Kinsler		18. Mother's Name (First, Middle, Maiden Surname) Emma Kinsler		
	19a. Informant's Name/Relationship (Type, Print) Tony Randall-Grandson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4332 Danlou Drive, Baltimore Md 21207		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		20c. Location - City or Town, State 8/18/00 Arbutus, Md
	21. Signature of Funeral Service Licensee <i>Jerome A. Shimp</i>		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215		
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORONARY ARTERY DISEASE				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28b. Time of Injury		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and Title of Certifier <i>Jeffrey Lotlikar</i>		29c. License number DS0229		29d. Date signed (Month, Day, Year) 8/16/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY LOTLIKAR, MD 4660 Wickens Ave, Balt 21229					
State Registrar	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature <i>Sparks</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26482

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORA J. LAKER				2. Date of Death Month Day Year August 20 2000		3. Time of Death 1:01 AM	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 238-16 6051	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec-27, 1909		9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3808 OVERLEA AVE				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry AT HOME	
17. Father's Name (First, Middle, Last) PRESTON JACKSON				18. Mother's Name (First, Middle, Maiden Surname) DELLA JACKSON				
19a. Informant's Name/Relationship (Type, Print) EARL W. BLACKMON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 OVERLEA AVE. BALTIMORE, MARYLAND 21206				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NEW LATHROPAL		Date AUG 22, 2000		20c. Location - City or Town, State BALTIMORE, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21234 8800 HARBOR ROAD PARKERS MARYLAND				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier J. SUMNER MD				29c. License number D25753		29d. Date signed (Month, Day, Year) August 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIA SUMNER, M.D., 5601 Loch Raven Blvd, Baltimore, MD 21239								
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. If the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26483

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) LEODA LINK				2. Date of Death Month Day Year August 17th 2000		3. Time of Death 1:45 PM							
4a. Facility Name (If not institution, give street and number) Riverview Nursing Home				4b. City, Town, or Location of Death N/A		4c. County of Death Baltimore							
5. Social Security Number 234-44-7067		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 9, 1915							
9. Birthplace (State or Foreign Country) Maryland													
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number 1053 Horners Lane				10f. Zip Code 21205		10g. Citizen of What Country? U.S.A.							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Onw Home							
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Rosie Thomas									
19a. Informant's Name/Relationship (Type, Print) William Holmes (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1053 Horners Lane Baltimore, Maryland 21205									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		20c. Date 8/21/00		20d. Location - City or Town, State Glen Burnie, Maryland							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Respiratory failure Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death less than one week </td> </tr> <tr> <td>b. Pneumonia Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory failure Due to (or as a consequence of):	Approximate Interval Between Onset and Death less than one week	b. Pneumonia Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory failure Due to (or as a consequence of):	Approximate Interval Between Onset and Death less than one week											
	b. Pneumonia Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number D 30661		29d. Date signed (Month, Day, Year) August 18th 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sireesh TRIPURANGANI 1 Eastern Blvd. Baltimore, Md - 21221													
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Patrick Anthony Long

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, PER MEO *Certificate of Death* WR.

Reg. No.

00 26484

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICK ANTHONY LONG		2. Date of Death Month Day Year August 17 2000		3. Time of Death 04:00 P.M.
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 217-56-2744	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug. 02 1960		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Md.		10b. County Anne Arundel Co.		10c. City, Town or Location Pasadena	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3503 D Davenport Court			10f. Zip Code 21122		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Servant		16b. Kind of Business/Industry U.S. Government
17. Father's Name (First, Middle, Last) Hubert F. Long			18. Mother's Name (First, Middle, Maiden Surname) Joann D. Riley		
19a. Informant's Name/Relationship (Type, Print) Druscilla L. Burke (Sister)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 734 Larue Road, Millersville, Md. 21108		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 8/21/2000	20c. Location - City or Town, State Baltimore, Md.
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="text-align: center;">HYPERTENSIVE CARDIOVASCULAR DISEASE</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANNE D. KOREN 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26485

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Pauline Legum</u>		2. Date of Death Month <u>August</u> Day <u>18</u> Year <u>2000</u>		3. Time of Death <u>6:50 PM</u>
	4a. Facility Name (If not institution, give street and number) <u>Northwest Hospital Center</u>		4b. City, Town, or Location of Death <u>RANDALLSTOWN</u>		4c. County of Death <u>Baltimore County</u>
Funeral Director	5. Social Security Number <u>220-50-3564</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>89</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>NOV. 30, 1910</u>		9. Birthplace (State or Foreign Country) <u>NEW YORK</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>BALTIMORE</u>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <u>2331 OLD COURT ROAD #201</u>			10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>HOMEMAKER</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>OWN HOME</u>		16b. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) <u>HARRY RUBIN</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>MINNIE ASHER</u>			
19a. Informant's Name/Relationship (Type, Print) <u>DR. RONALD LEGUM / SON</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>R.R.1, BOX 4421, BAYVIEW AVE. SEDGWICK, MAINE 04676</u>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>HAR SINAI CONGREGATION</u>		20c. Location - City or Town, State <u>8/20/00 OWINGS MILLS, MD.</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>SOL LEVINSON & BROS. INC.</u> <u>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <u>Multiple organ system failure</u> Due to (or as a consequence of): b. <u>Systemic inflammatory response syndrome</u> Due to (or as a consequence of): c. <u>Acute leukemia</u> Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death <u>12 hours</u> <u>>24 hours</u> <u>>2 months</u>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Osteoporosis</u> <u>Hypertension</u>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>August 18, 2000</u>		28b. Time of Injury <u>M</u>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature] MD</u>		29c. License number <u>D28462</u>	
29d. Date signed (Month, Day, Year) <u>August 18, 2000</u>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>J Boston Northwest Hospital Center Randallstown Maryland</u>					
31. Date filed (Month, Day, Year) <u>AUG 22 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS #20b-c PER FH G786 8/22/00 AH

Certificate of Death

Reg. No.

00 26486

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John T. Linster, Jr.				2. Date of Death Month Day Year August 14, 2000				3. Time of Death 7:30pm	
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care-Loch Raven				4b. City, Town, or Location of Death Parkville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 222-16-8718		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Nov 13, 1930		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10a. Street and Number 8313 Nunley Drive Apt D		10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 50-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative		16b. Kind of Business/Industry State of Maryland			
	17. Father's Name (First, Middle, Last) John T. Linster, Sr				18. Mother's Name (First, Middle, Maiden Surname) Carrie Snyder					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mildred Linster				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8313 Nunley Drive, Apt D Parkville Md 21234					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial GARRISON FOREST VETERANS CEMETERY		Date Aug 18 2000		20c. Location - City or Town, State Timonium, MD GARRISON, MD			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Acute Pneumonia</i> Due to (or as a consequence of): b. <i>dysphagia</i> Due to (or as a consequence of): c. <i>cerebrovascular accident</i> Due to (or as a consequence of): d. <i>atrial fibrillation</i>				Approximate Interval Between Onset and Death 1 3 yrs. unknown unknown					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D28987	
	29d. Date signed (Month, Day, Year) 8-16-00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALD. MD 21239					
State Registrar	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature <i>[Signature]</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #5 PER FH G787 9/6/00AH
AMENDED ITEM #5 PER FH G786 8/22/00 AH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26487

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Anna Miller				2. Date of Death Month Day Year August 16 2000		3. Time of Death 12:28 P	
Funeral Director		4a. Facility Name (If not institution, give street and number) Mercy Medical Center				4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore	
5. 217-22-4997 217-22-4997		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) January 26, 1927	
Usual Residence of Decedent		10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2508 Anders Rd.				10f. Zip Code 21234		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Towson Courthouse			
17. Father's Name (First, Middle, Last) Andro Kovalic				18. Mother's Name (First, Middle, Maiden Summa) Anna Petro					
19a. Informant's Name/Relationship (Type, Print) Andrea L. Tracey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 E. Amberleaf Trail, Westfield, IN 46074					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date Aug 19 2000		20c. Location - City or Town, State Parkville, MD	
21. Signature of Funeral Service Licensee <i>Kevin S. Wells</i>				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd., Parkville, MD					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardio Respiratory Arrest Due to (or as a consequence of): b. OVARIAN CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier <i>Neil B. Rosenheim</i>		29c. License number D08372		29d. Date signed (Month, Day, Year) August 16, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Neil B. Rosenheim, Mercy Medical Center, Balto, Md 21202									
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature <i>Sparks</i>							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 25488

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY MAE MADDEN

2. Date of Death

Month Day Year
AUGUST 15, 2000 3:45 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-34-4164

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC 22, 1937

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

COCKEYSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

14107 CUBA RD.

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
BLACK15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

ROBERT

TYLER

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY

MATTHEWS

19a. Informant's Name/Relationship (Type, Print)

ERNEST C. MADDEN, SR., SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14107 CUBA RD. COCKEYSVILLE, MD. 21030

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
GARRISON FOREST
VETERANS CEMETERY

Date

AUG. 21
2000

20c. Location - City or Town, State

GARRISON, MD.

21. Signature of Funeral Service Licensee

John P. F.

22. Name and Address of Facility

EVANS FUNERAL CHAPEL

2325 YORK RD. TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

LIVER AND RENAL FAILURE DUE TO

Approximate
Interval Between
Onset and Death

WEEKS

a. Due to (or as a consequence of):

LIVER CIRRHOSIS

YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Natividad D. de Leon, M.D.

29c. License number

D 19508

29d. Date signed (Month, Day, Year)

8/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIVIDAD D. de LEON, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

Shirley B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26489

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Antonio J. Mosca				2. Date of Death Month Day Year August 17, 2000				3. Time of Death 6:53pm	
	4a. Facility Name (If not institution, give street and number) 12820 Long Green Pike				4b. City, Town, or Location of Death Long Green				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-16-9315		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) May 30, 1924		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 2809 B Kings Ridge Rd.				10f. Zip Code 21234				10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brick layer				16b. Kind of Business/Industry Construction	
	17. Father's Name (First, Middle, Last) Joseph Mosca				18. Mother's Name (First, Middle, Maiden Surname) FRANCES SURRENTINO					
	19a. Informant's Name/Relationship (Type, Print) Helen Mosca				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 B Kings Ridge Rd., Parkville, MD 21234					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date Aug 21 2000		20c. Location - City or Town, State Rosedale, MD			
	21. Signature of Funeral Service Licensee <i>Kevin S. Wells</i>				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, MD					
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>ASCVD</i> Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus, Type II</i> <i>Hypertension / Chronic</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital:		26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>VINEYARD</i>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>Robert Y. Hsiao</i>				29c. License number 35305				29d. Date signed (Month, Day, Year) AUGUST 21, 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. Robert Y. HSIAO 5601 Loch Raven Blvd. Baltimore, Md									
	31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature <i>Berena B. Sparks</i>					
	State Registrar									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26490

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN Wesley MORGAN				2. Date of Death Month Day Year August 17 2000		3. Time of Death 0153	
	4a. Facility Name (If not institution, give street and number) ER FALLSTON GENERAL HOSPITAL				4b. City, Town, or Location of Death FALLSTON		4c. County of Death HARFORD	
Funeral Director	5. Social Security Number 218-42-8550		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) MAY 21, 1945	
	9. Birthplace (State or Foreign Country) TENNESSEE		10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location DARLINGTON	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4104-16 CONOWINGO ROAD		10f. Zip Code 21034		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12YRS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPPORT MANAGER		16b. Kind of Business/Industry WAL MART STORE #2009		16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAL MART STORE #2009		
17. Father's Name (First, Middle, Last) DANIEL LEE MORGAN				18. Mother's Name (First, Middle, Maiden Surname) RUBY LEE POPE				
19a. Informant's Name/Relationship (Type, Print) TERESA MAE MORGAN				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4104-16 CONOWINGO ROAD DARLINGTON, MARYLAND 21034				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL - BAL AIR, P.A.		20c. Location - City or Town, State FOREST HILL MARY		20d. Date AUG 18, 2000		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility EVANS FUNERAL CHAPEL - BAL AIR, P.A. 21050		22. Name and Address of Facility 3 NEWPORT DRIVE FOREST HILL MARYLAND		22. Name and Address of Facility 3 NEWPORT DRIVE FOREST HILL MARYLAND		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE LYMPHATIC LEUKEMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier DME		29c. License number OCME		29d. Date signed (Month, Day, Year) AUG 17, 2000		29d. Date signed (Month, Day, Year) AUG 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 95 PABST RD 728 BELAIR MD BELAIR MD 21014								
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26491

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Mayo, V				2. Date of Death Month Day Year August 20, 2000		3. Time of Death 4:21 PM	
	4a. Facility Name (If not institution, give street and number) 921 Upper Glencoe Road				4b. City, Town, or Location of Death Glencoe		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-26-1621		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Oct 24, 1928	
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Glencoe		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 921 Upper Glencoe Road				10f. Zip Code 21152		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) n/a				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) President & CEO			16b. Kind of Business/Industry The Middleton & Meads Co., Inc.	
17. Father's Name (First, Middle, Last) George Mayo, IV				18. Mother's Name (First, Middle, Maiden Surname) Edith Germaine Gorsuch				
19a. Informant's Name/Relationship (Type, Print) Helen Mayo/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Upper Glencoe Road, Sparks, MD 21152				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gorsuch Family Cemetery		20c. Location - City or Town, State 8/23/00 Glencoe, Maryland		
21. Signature of Funeral Service Director Bryan W. Clary				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093				
23a. Pertinent disease, or condition, or cause of death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC PROSTATIC CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Robert Wiedefeld MD				29c. License number D33011		29d. Date signed (Month, Day, Year) 8-21-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Wiedefeld, MD 3346 Papermill Road Phoenix, MD 21131								
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature Benjamin B Sparks				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26492

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN M. MERRITT				2. Date of Death Month 08 Day 16 Year 2000		3. Time of Death 3:30 P.M.	
	4a. Facility Name (If not institution, give street and number) 3411 DILLON ST.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-28-3051	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APR. 16, 1932		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3411 DILLON ST.				10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) WILLIAM J. CARRIGAN				18. Mother's Name (First, Middle, Maiden Surname) CAROLINE GRAULING				
19a. Informant's Name/Relationship (Type, Print) JOHN N. MERRITT				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 DILLON ST. BALTIMORE, MD. 21224				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILL CEM.		Date AUG 19 2000		20c. Location - City or Town, State BALTO. CO. MD.		
21. Signature of Funeral Service Licensee Thomas J. Skarda				22. Name and Address of Facility HEFFERNAN-SKARDA 3218 HUDSON ST. BALTO., MD. 21224				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BREAST CANCER Due to (or as a consequence of): b. LUNG CANCER Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier James E. Quinn, MD				29c. License number D38033		29d. Date signed (Month, Day, Year) 8/17/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRENE E. IBARRA 261 S. HIGHLAND AVE. BALTO. MD. 21224								
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature James E. Quinn						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26498

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Martin		2. Date of Death Month August Day 17 , Year 2000		3. Time of Death 2:50 pm
	4a. Facility Name (If not institution, give street and number) Stella Maris of Timonium		4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 218-22-7177	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct. 17, 1910		9. Birthplace (State or Foreign Country) South Carolina		
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1827 N. Monroe St.		10f. Zip Code 21217
	10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Private
	17. Father's Name (First, Middle, Last) Percell Dubose		18. Mother's Name (First, Middle, Maiden Surname) Louise Dubose		
	19a. Informant's Name/Relationship (Type, Print) (Son) Mr. John Fenwick		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3826 Derby Manor Drive		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park		20c. Location - City or Town, State Balto. Md.
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)				
	a. ARTERIOSCLEOTIC HEART DISEASE Due to (or as a consequence of):				
	b. Due to (or as a consequence of):				
	c. Due to (or as a consequence of):				
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Joseph L. Russ		29c. License number D 15504		29d. Date signed (Month, Day, Year) 8. 17. 00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093					
State Registrar	31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature B. Spence		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 26494

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Irene Moore

2. Date of Death

August 19, 2000

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

196-38-2226

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 29, 1900

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2503 Violet Ave. APT. 1209S

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Outside Home

17. Father's Name (First, Middle, Last)

Oscar Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edmonds

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elizabeth C. Bacon (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2501 Violet Ave. APT. 611N Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

8/24/00

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amatun H. Hloern

29c. License number

D15503

29d. Date signed (Month, Day, Year)

August 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amatun Hloern, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

[Signature]

ORIGINAL

MARY MOORE
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26495

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Winifred NMN Miller

2. Date of Death

August 10 2000

3. Time of Death

1210 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital Emergency Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

375-28-8131

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 29, 1929

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

304 Ilchester Ave.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Honey Bee

17. Father's Name (First, Middle, Last)

unk.

18. Mother's Name (First, Middle, Maiden Surname)

unk.

19a. Informant's Name/Relationship (Type, Print) (Son)

Mr. David Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 Ilchester Ave. Balto. Md. 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory

Date

8/17/2000

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Protein Calorie Malnutrition

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Schizophrenia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular Accident

Decubitus Ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher M Price MD

29c. License number

D43564

29d. Date signed (Month, Day, Year)

August 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher M Price 3333 N. Calvert St. Ste 515 Baltin

31. Date filed (Month, Day, Year)

AUG 8 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26496

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bessie Viola Meister

2. Date of Death

August 21, 2000

3. Time of Death

5:30 A.M.

4a. Facility Name (If not institution, give street and number)

Mariner Health of North Arundel

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214-18-6023

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 26, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

218 Oak Drive

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Merchandising Dept.

16b. Kind of Business/Industry

Hutzlers

17. Father's Name (First, Middle, Last)

Louis Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Florence Preston

19a. Informant's Name/Relationship (Type, Print)

Alice LeCompte (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

218 Oak Drive Pasadena, Maryland 21122

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/24/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pulmonary Hypertension Primary 4 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending
investigation☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26307

29d. Date signed (Month, Day, Year)

8/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RANI S. KARIPINEN
4000 ANNAPOLIS RD, BALTIMORE, MD 21227

31. Date filed (Month, Day, Year)

AUG 22 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 26497

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Rose Mioduszewski</u>				2. Date of Death Month <u>August</u> Day <u>16</u> Year <u>2000</u>		3. Time of Death <u>6:00 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Harbor Hospital Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>216-05-5389</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 27, 1913</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>306 Seward Ave</u>		10f. Zip Code <u>21225</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>N/A</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Seamstress</u>		16b. Kind of Business/Industry <u>Tayloring Company</u>				
17. Father's Name (First, Middle, Last) <u>Charles Frank Grahe</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Jennie Johnson</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Arthur M. Mioduszewski, Jr-Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>208 Maple Ave Glen Burnie, Maryland 21061</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		20c. Location - City or Town, State <u>8/21/00 Brooklyn Park, Md.</u>				
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>McCully-Polyniak Funeral Home, P.A.</u> <u>3204 Mountain Road Pasadena, Maryland 21122</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Ventricular Fibrillation</u> Due to (or as a consequence of): <u>b. Cardiac Ischemia</u> Due to (or as a consequence of): <u>c. Coronary Artery Disease</u> Due to (or as a consequence of): <u>d.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>30 minutes</u> <u>60 minutes</u> <u>30 years</u>								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>Atrial Fibrillation</u> <u>Hypertension</u> <u>Dementia</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>D0052022</u>		29d. Date signed (Month, Day, Year) <u>August 16, 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Harbor Hospital 3001 South Hanover Street, Baltimore, MD 21225</u>								
31. Date filed (Month, Day, Year) <u>AUG 22 2000</u>		32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

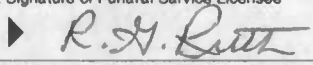
State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F P. MEO G787 9-6-00 WR.

Certificate of Death

Reg. No.

00 26498

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS J. MAIALE				2. Date of Death Month Day Year AUGUST 19, 2000		3. Time of Death 3:23 P.M.	
	4a. Facility Name (If not institution, give street and number) ON the BEACH AT 13th STREET				4b. City, Town, or Location of Death OCEAN CITY		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 162-46-4089	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 03/20/1954		9. Birthplace (State or Foreign Country) PENNSYLVANIA
	Usual Residence of Decedent							
10a. State PA.		10b. County WESTTOWN		10c. City, Town or Location WEST CHESTER			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 19 RIDGE RD.				10f. Zip Code 19382		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1YR.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FIELD SERVICE TECH.			16b. Kind of Business/Industry COMPUTER	
17. Father's Name (First, Middle, Last) ANTHONY W. MAIALE				18. Mother's Name (First, Middle, Maiden Surname) WILLETTA HARGROVE				
19a. Informant's Name/Relationship (Type, Print) CAROLYN M. MAIALE(WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 RIDGE RD. WEST CHESTER, PA. 19382.				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BIRMINGHAM-LAFAYETTE		20c. Location - City or Town, State 08/24/2000 WEST CHESTER, PA.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEIZURE DISORDER ASSOCIATED WITH DROWNING						Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE				
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 8-19-00		28b. Time of Injury 2:31 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) WATER		28f. Location (Street and Number or Rural Route Number, City or Town, State) 13th ST. & BEACH, Ocean City, MD.		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier 				
29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) AUGUST 20, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. L. L. L. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) AUG 22 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 26400
3:00 AM

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Scott Eugene Muntean						2. Date of Death Month 8 Day 17 Year 00		3. Time of Death 3:00 AM	
	4a. Facility Name (If not institution, give street and number) 100 Askewton Road						4b. City, Town, or Location of Death Severna Park		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 278-52-7427		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) NOV 10, 1954		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Severna Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 100 Askewton Road				10f. Zip Code 21146		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pilot			16b. Kind of Business/Industry Aviation Sales			
17. Father's Name (First, Middle, Last) Eugene John Muntean						18. Mother's Name (First, Middle, Maiden Surname) Amelia Irene Longociu				
19a. Informant's Name/Relationship (Type, Print) Nancy A. Lynn/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Askewton Road Severna Park, MD 21146						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 8/18/00		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GLIOBLASTOMA MULTIFORME Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 22 MONTHS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Sharon Gorman MD				29c. License number D23683		29d. Date signed (Month, Day, Year) 8/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLEY GROSSMAN MD, JOHNS HOPKINS ONCOLOGY CENTER BALTIMORE, MD										
31. Date filed (Month, Day, Year) AUG 22 2000		32. Registrar's Signature Benjamin G. Sparks								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7 PER F.H. G787 9-16-00 •Certificate of Death

Reg. No.

00 26500

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BLAIRE J. PANICHO					2. Date of Death Month AUGUST Day 16 Year 2000		3. Time of Death 12:34 P.M.							
	4a. Facility Name (If not institution, give street and number) MANOR CARE					4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE							
Funeral Director	5. Social Security Number 218-10-4390		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) FEBRUARY 3, 1916		9. Birthplace (State or Foreign Country) MARYLAND						
	Usual Residence of Decedent														
10a. State MARYLAND			10b. County BALTIMORE		10c. City, Town or Location PARKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 7808 WESTMORELAND AVE.					10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+)					16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MERCHANT MARINE			16b. Kind of Business/Industry MARITIME							
17. Father's Name (First, Middle, Last) FRANCIS PANICHO					18. Mother's Name (First, Middle, Maiden Surname) ROSE DITULIO										
19a. Informant's Name/Relationship (Type, Print) VICTOR PANICHO					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7808 WESTMORELAND AVE. PARKVILLE, MARYLAND 21234										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL - BALTIMORE, P.A.			Date AUG 18, 2000		20c. Location - City or Town, State FOREST HILL, MARYLAND 21234							
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility EVANS FUNERAL CHAPEL 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234										
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:70%;"> a. Sementor Due to (or as a consequence of): </td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td> b. UROSEPSIS Due to (or as a consequence of): </td> </tr> <tr> <td> c. Due to (or as a consequence of): </td> </tr> <tr> <td> d. Due to (or as a consequence of): </td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. Sementor Due to (or as a consequence of):	{	b. UROSEPSIS Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Sementor Due to (or as a consequence of):														
{	b. UROSEPSIS Due to (or as a consequence of):														
	c. Due to (or as a consequence of):														
	d. Due to (or as a consequence of):														
	<table border="0" style="width:100%;"> <tr> <td style="width:70%;"> 23b. Dtd tobacco use contributes to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown </td> <td style="width:30%; vertical-align: top;"> Approximate Interval Between Onset and Death > 3 years 7 days </td> </tr> </table>										23b. Dtd tobacco use contributes to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	Approximate Interval Between Onset and Death > 3 years 7 days			
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<table border="0" style="width:100%;"> <tr> <td style="width:70%;"> 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> <td style="width:30%;"> 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> </table>										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
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<table border="0" style="width:100%;"> <tr> <td style="width:30%;"> 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> <td style="width:70%;"> 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) </td> </tr> </table>										25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
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<table border="0" style="width:100%;"> <tr> <td style="width:30%;"> 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined </td> <td style="width:70%;"> 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) </td> </tr> </table>										27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier 					29c. License number D42736		29d. Date signed (Month, Day, Year) AUGUST 17, 2000								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AYMAN F. AKKAI, P.O. 7600 OSLER DRIVE - TOWSON															
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">31. Date filed (Month, Day, Year) AUG 22 2000</td> <td style="width:70%;">32. Registrar's Signature </td> </tr> </table>										31. Date filed (Month, Day, Year) AUG 22 2000	32. Registrar's Signature 				
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

